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PRESIDENT'S HEALTH AND HUMAN SERVICES BUDGET PROPOSALS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

FEBRUARY 23, 1987

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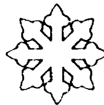

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PRESIDENT'S HEALTH AND HUMAN SERVICES BUDGET PROPOSALS

MONDAY, FEBRUARY 23, 1987

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

The committee met, pursuant to recess, at 2:30 p.m. in room SD-215, Dirksen Senate Office Building, the Honorable Spark M. Matsunaga presiding.

Present: Senators Matsunaga, Baucus, Mitchell, and Danforth.

[The press release announcing the hearing and the opening statements of Senators Matsunaga and Heinz follows:]

[Press Release]

CHAIRMAN BENTSEN ANNOUNCES HEARING ON THE PRESIDENT'S HEALTH AND HUMAN SERVICES BUDGET PROPOSALS

WASHINGTON, DC.—Senator Lloyd Bentsen (D., Texas), Chairman, announced Thursday that the Senate Finance Committee will hold a hearing on Monday, February 23, 1987 on the President's proposed budget for fiscal year 1988.

The witness for the hearing will be The Honorable Otis R. Bowen, M.D., Secretary for Health and Human Services.

Chairman Bentsen stated that the purpose of the hearing will be to examine the President's budget proposals that affect programs within the Committee's jurisdiction, including the Medicare, Medicaid, the Maternal and Child Health Block Grant, Aid to Families with Dependent Children, Child Support Enforcement and other social service and income maintenance programs.

"The President's budget has proposed significant spending reductions and structural changes in the basic health and income security programs, and the Committee needs to closely scrutinize these proposals to determine if spending can be reduced while preserving the quality of health care for the elderly and preserving the safety net for the poor", Chairman Bentsen stated.

The hearing will be chaired by Senator Spark Matsunaga (D., Hawaii). The hearing will begin at 2:30 P.M. on Monday, February 23, 1987 in Room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT
BY SENATOR SPARK MATSUNAGA
AT SENATE FINANCE COMMITTEE HEARING
MONDAY, FEBRUARY 23, 1987 - 2:30 PM

SECRETARY BOWEN, IT IS MY DISTINCT PLEASURE TO WELCOME YOU ONCE AGAIN TO THE FINANCE COMMITTEE FOR YOUR TESTIMONY THIS AFTERNOON.

FIRST OF ALL, I WOULD LIKE TO COMMEND YOU FOR YOUR FIRM LEADERSHIP IN TRANSLATING THE RECOMMENDATIONS OF YOUR TASK FORCE ON CATASTROPHIC HEALTH INSURANCE COVERAGE INTO LEGISLATION, WHICH IS SOON TO COME BEFORE THIS COMMITTEE FOR CONSIDERATION. THE ADMINISTRATION'S PLAN IS A STARTING POINT FOR SERIOUS DISCUSSION IN CONGRESS ON HOW TO MEET A GREAT, UNFILLED NEED. ACTION CERTAINLY NEEDS TO BE TAKEN TO REDUCE THE HIGH, OUT-OF-POCKET EXPENSES OF MEDICARE BENEFICIARIES WHO NEED REPEATED OR EXTENDED HOSPITALIZATION.

WE ALSO SHOULD SERIOUSLY CONSIDER FILLING SOME OF THE CRITICAL GAPS IN MEDICARE COVERAGE. I AM ESPECIALLY CONCERNED ABOUT ANOTHER GAP IN THE PRESIDENT'S PLAN -- LONG-TERM CARE PROTECTION. NURSING HOME CARE, HOME HEALTH AND HOME CARE, AND RELATED SERVICES LEAD TO ENORMOUS EXPENDITURES FOR MANY AND THERE IS MINIMAL INSURANCE PROTECTION AGAINST THOSE EXPENSES. MEDICARE COVERED ONLY TWO PERCENT OF NURSING HOME EXPENSES OF THE ELDERLY IN 1984.

MOVING ON TO THE MATTER BEFORE THE COMMITTEE TODAY, THE PRESIDENT'S FISCAL YEAR 1988 BUDGET PROPOSALS WHICH AFFECT PROGRAMS WITHIN THIS COMMITTEE'S JURISDICTION, I CERTAINLY RECOGNIZE THE BUDGETARY CONSTRAINTS UNDER WHICH WE ARE ALL OPERATING. THE MEDICARE AND MEDICAID PROGRAMS COMPRISE THE MAJOR PORTION OF THE FINANCE COMMITTEE DEFICIT REDUCTION PROPOSED IN THE PRESIDENT'S BUDGET.

I UNDERSTAND THE NEED TO CONTAIN RAPIDLY RISING COSTS IN THIS AREA; HOWEVER, I FEAR THAT MANY OF THE ADMINISTRATION'S PROPOSALS -- WHICH HAVE BEEN REPEATEDLY REJECTED BY CONGRESS -- WOULD RESULT IN REDUCING ESSENTIAL SERVICES OR SHIFTING THE COST BURDEN TO THE BENEFICIARIES THEMSELVES OR OTHER CONSUMERS. TO HEAP ADDITIONAL BURDENS UPON OUR SENIOR CITIZENS AND OTHERS WHO CANNOT AFFORD QUALITY MEDICAL CARE IS UNCONSCIONABLE.

ONE PROPOSAL WHICH HAS BEEN SOUNDLY REJECTED BY CONGRESS IN THE PAST FOUR YEARS IS THE MEDICAID CAP. THIS YEAR THE ADMINISTRATION PROPOSES TO REDUCE FEDERAL MEDICAID SPENDING BY $1.2 BILLION BELOW THE CURRENT PROGRAM ESTIMATE. THIS PROPOSED REDUCTION COMES AT A TIME WHEN SO MANY DEPEND ON MEDICAID TO PAY FOR THEIR NURSING HOME CARE, AND WHEN BOTH CONGRESS AND THE ADMINISTRATION ARE TRYING TO ENCOURAGE STATES

TO PURSUE PRENATAL AND EARLY CHILDHOOD HEALTH INITIATIVES. THE DEMAND ON STATES TO MEET MEDICAID SHORTFALLS IN THE FACE OF GROWING DEMANDS AND NEEDS IS IN MY VIEW UNREASONABLE.

IN MY STATE OF HAWAII, MEDICAID CLIENTS ARE HAVING TROUBLE FINDING DENTISTS AND DOCTORS TO CARE FOR THEM BECAUSE STATE PAYMENTS ARE MUCH TOO LOW. MANY PROVIDERS ARE REFUSING TO TAKE NEW MEDICAID CLIENTS BECAUSE THEY CAN EXPECT ONLY ABOUT 40 CENTS ON A DOLLAR FOR THEIR SERVICES. THE RATES HAVE NOT BEEN INCREASED SINCE 1980. IN FACT, THEY WERE REDUCED 10% IN 1983 AND 1984 BECAUSE OF STATE BUDGET PROBLEMS. ACCESS TO CARE IS BEING SEVERELY COMPROMISED. FOR EXAMPLE, MEDICAID CLIENTS ON THE ISLAND OF KAUAI ARE BEING FLOWN TO HONOLULU, ON THE ISLAND OF OAHU, TO SEE DENTISTS. THIS MAKES NO SENSE -- AND THE MEDICAID CAP WOULD EXACERBATE THESE SITUATIONS.

I AM CONCERNED ALSO ABOUT THE PRESIDENT'S PROPOSAL TO REPEAL SPECIFIED PROVISIONS ENACTED IN THE OMNIBUS BUDGET RECONCILIATION ACT (OBRA) OF 1986, PARTICULARLY THE LIMITED EXPANSION OF MEDICARE PART B COVERAGE OF OCCUPATIONAL THERAPY SERVICES.

FURTHERMORE, I SERIOUSLY QUESTION THE ELIMINATION OF MEDICARE PAYMENTS FOR UNDERGRADUATE NURSING AND ALLIED HEALTH PROFESSIONAL EDUCATION. MANY AREAS OF THE COUNTRY, ESPECIALLY RURAL AND ISOLATED AREAS, ARE EXPERIENCING NURSING SHORTAGES. ONE WOULD NOT EXPECT HAWAII -- THE PARADISE OF THE PACIFIC -- TO FACE THIS PROBLEM. HOWEVER, WE DO HAVE A SHORTAGE OF 500 NURSES AND AN ATTRITION RATE OF 150 NURSE PER YEAR. NURSES AND ALLIED HEALTH PROFESSIONALS PLAY AN ESSENTIAL AND I BELIEVE, A COST-EFFICIENT ROLE IN THE CARE OF MEDICARE PATIENTS.

MR. SECRETARY, I WOULD GREATLY APPRECIATE AN EXPLANATION OF YOUR PROPOSAL TO REFORM MEDICARE'S PAYMENT MECHANISM FOR RADIOLOGISTS, ANESTHESIOLOGISTS, AND PATHOLOGISTS (RAPs) BY HAVING MEDICARE PAY AN AVERAGE AREA PRICE FOR HOSPITAL-BASED PHYSICIAN SERVICES. I WOULD LIKE TO HEAR MORE ABOUT HOW THIS FITS IN WITH ANY LONG-TERM PLAN FOR CHANGING THE PAYMENT SYSTEM FOR ALL PHYSICIANS AND WHAT THE IMPACT ON BENEFICIARIES MAY BE, SINCE BALANCE BILLING BY RAP PHYSICIANS WOULD BE ALLOWED.

I AM ALSO INTERESTED IN LEARNING MORE ABOUT THE "GREATER OPPORTUNITIES THROUGH WORK" (GROW) PROPOSAL DESIGNED TO INCREASE THE SELF-SUFFICIENCY OF RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC).

I LOOK FORWARD TO HEARING YOUR TESTIMONY AND RESPONSES TO THE COMMITTEE MEMBERS' QUESTIONS. LET ME ASSURE YOU THAT WE STAND READY TO WORK CLOSELY WITH YOU IN THE DIFFICULT TASK OF SEEKING DEFICIT REDUCTION WITHOUT ABANDONING FUNDAMENTAL RESPONSIBILITIES.

OPENING STATEMENT
SENATOR JOHN HEINZ (R-PA)
SENATE FINANCE COMMITTEE HEARING ON THE FY1988 DHHS BUDGET
23 FEBRUARY 1987 2:30 PM

Dr. Bowen, you are becoming a familar face at the witness table. I'd like to use this opportunity to make a few general obsevations and raise a few general concerns about the Department's budget.

Democrat and Republican alike, members of this Committee stand united in our determination to break the stranglehold of a multi-billion dollar deficit on our national economy. But Mr. Secretary, as committed as I am personally to deficit reduction, I can only approach the recommendations before us today with caution.

I am concerned, first of all, that this budget perpetuates a dangerous trend. That when OMB's computer lights come up CUT, the Administration's automatic response is to punch in MEDICARE. Over the past six years we've cut total Medicare program expenses by almost $40 billion. We're now asked to approve another $50 billion in program cuts, premium increases and other financing gimmicks--most of which would fall heavily on the backs of beneficiaries.

We may have corseted Medicare tightly enough, Mr. Secretary. I am concerned that further constrictions in spending will only threaten the quality of care and the financial security of our Nation's oldest and most vulnerable citizens. A case in point are the monies allotted Congress's quality watchdogs, the Peer Review Organizations. My question is whether $176 million is enough for the PROs to do their old job and carry out the critical new responsibilities mandated by OBRA.

I am concerned, too, with the proposed $1.3 billion cuts and the cost cap for Medicaid. Not only would we be changing the program from an entitlement to block grant, but we would reduce spending by close to 5 percent at the same time we anticipate an almost 2 percent increase in eligibility.

You came before us an Angel of Mercy with your catastrophic proposal last month, Mr. Secretary. That role becomes you--I hope you can allay some of these other concerns for us today.

Senator MATSUNAGA. The Committee on Finance will come to order.

Secretary Bowen, it is my distinct pleasure indeed to welcome you once again to testify before this committee. At the outset, I would like to commend you for your firm leadership in translating the recommendations of your Task Force on Catastrophic Health Insurance Coverage into legislation, which we hope we will be considering very soon.

The Administration's plan is a starting point for serious consideration by Congress on how to meet a great unmatched need. Action certainly needs to be taken to reduce the high out-of-pocket expenses of Medicare beneficiaries who need repeated or extended hospitalization.

We should also seriously consider filling some of the critical gaps in Medicare coverage, and I am especially concerned about another gap in the President's plan, long term care protection, and nursing home care, home health and home care and related services that lead into enormous expenditures for many and there is minimal insurance protection against those expenses.

Medicare covered only 2 percent of nursing home expenses of the elderly in 1984. And I note from that wonderful article written about you in the Journal that you, yourself, experienced, or your family, some hardship.

Moving on to the matter before the committee today, the President's fiscal year 1988 budget proposals, which affect programs within this committee's jurisdiction. I certainly recognize the budgetary constraints under which we must operate.

The Medicare and Medicaid programs comprise the major portion of the Finance Committee deficit reduction proposed in the President's budget. I understand the need to contain rapidly rising costs in this area; however, I fear that many of the Administration's proposals, which incidentally have been repeatedly rejected by Congress, would result in reducing essential services or shifting the cost burden to the beneficiaries themselves or other consumers. To heap additional burdens upon our senior citizens and others who cannot afford quality medical care are, to me, unconscionable.

One proposal which has been soundly rejected by Congress in the past four years is the Medicaid cap. This year, the Administration proposes to reduce federal Medicaid spending by $1.2 billion below the current program estimate. This proposed reduction comes at a time when so many depend on Medicaid to pay for their nursing home care. And when both Congress and the Administration are trying to encourage States to pursue prenatal and early childhood health initiatives, the demand on States to meet Medicaid shortfalls in the face of growing demands and needs is, in my view, unreasonable.

In my State of Hawaii, Medicaid clients are already having trouble finding dentists and doctors to care for them because State payments are much too low. Many providers are refusing to take new Medicaid clients because they can expect only about 40 cents on a dollar for their services. The rates have not been increased since 1980. In fact, they were reduced 10 percent in 1983 and 1984 because of State budget problems. Access to care is being serverely compromised.

For example, Medicaid clients on the Island of Kauai, my home island, are being flown to Honolulu, on the Island of Oahu, to see dentists. This makes no sense, and the Medicaid cap would exaggerate these situations.

I am also concerned about the President's proposal to repeal specified provisions enacted in the Omnibus Budget Reconciliation Act of 1986, particularly the limited expansion of Medicare Part B coverage of occupational therapy services.

Furthermore, I seriously question the elimination of Medicare payments for undergraduate nursing and allied health professional education. Many areas of the country, especially rural and isolated areas, are experiencing serious nursing shortages. One would not expect Hawaii, the paradise of the Pacific, to face this problem. However, we do have a shortage of 500 nurses and an attrition rate of 150 nurses per year. Nurses and allied health professionals play an essential, and I believe, a cost-efficient role in the care of Medicare patients.

Mr. Secretary, I would greatly appreciate an explanation of your proposal to reform Medicare's payment mechanism for radiologists, anesthesiologists, and pathologists, or RAPs, by having Medicare pay an average area price for hospital-based physician services. I would like to hear more about how this fits in with any long-term plan for changing the payment system for all physicians and what the impact on beneficiaries may be, since balance billing by RAP physicians would be allowed.

I am also interested in learning more about the "Greater Opportunities Through Work," or GROW, proposal designed to imcreased the self-sufficiency of recipients of Aid to Families with Dependent Children.

I look forward to hearing your testimony and responses to the committee members' questions. Let me assure you that we stand ready to work closely with you in the difficult task of seeking deficit reduction without abandoning fundamental responsibilities.

Senator Mitchell, do you have an opening statement?

Senator MITCHELL. Yes, I do, Mr. Chairman.

I thank you very much. I welcome Secretary Bowen and Mr. Burke and look forward to hearing your testimony today. As you know, the committee has already had an opportunity to examine the President's budget with the appearance last week of the Director of the Office of Management and Budget. As I expressed to Mr. Miller at that time, and I repeat today, a number of provisions in this budget are identical to the ones which have been soundly rejected by the Congress in the past. While I share the President's concern about the deficit, and I know you share that concern as well, I must object to the inequitable manner in which many of the recommended cuts are distributed.

The proposal to cap the Medicaid budget is most troubling in this regard. At a time of growing need for long-term care for the elderly, it is simply unrealistic to propose capping the Medicare budget in the form proposed by the Administration. The medicaid budget provides nearly 50 percent of funding for nursing home services nationally.

In many States, the burden of funding for nursing home care already consumes more than half of the total of the State's Medicaid

budget. The cap would discourage the use also of the optional and waivered Medicaid benefits Congress has legislated to encourage alternatives to nursing home use.

Another concern I have concerns the burden that current cost containment efforts have on the prospective payment system, the burden is being placed on small rural hospitals. These hospitals are often the only health care facilities within a reasonable distance of many of our citizens, and in States such as Maine, even relatively short distances may present formidable barriers to travel during the winter months. I do not see anything in your proposed budget that addresses the needs of small rural hospitals.

Despite these concerns and others, I assure you that I share your desire to see that the American people get the maximum possible benefit from federal expenditures to health care. I look forward to working with you, Mr. Secretary, and with Mr. Burke, and others, to try to achieve our common geal of quality health care readily accessible at an affordable cost for all Americans.

Thank you, Mr. Chairman.

Senator MATSUNAGA. Mr. Secretary, we would be happy to hear from you now.

STATEMENT OF THE HONORABLE OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES ACCOMPANIED BY MR. TOM BURKE, CHIEF OF STAFF

Secretary BOWEN. Thank you very much, and good afternoon, Mr. Chairman, and Senator Mitchell.

With me today is Tom Burke, my Chief of Staff.

I do appreciate the opportunity to appear before you again, this time for the purpose of advocating the proposals in the President's fiscal year 1988 Health and Human Services budget which fall under the jurisdiction of the Finance Committee.

Mr. Chairman, your committee has jurisdiction over programs forcing the very heart of the Department and affecting the lives of so many of this nation's citizens, including: Medicare; Medicaid, Social Security; Aid to Families with Dependent Children; and Supplemental Security Income.

In the past 14 months, your membership has voted to confirm me as Secretary of Health and Human Services. You have approved my Under Secretary, the Administrator of the Health Care Financing Administration, and the Commissioner of Social Security. The special relationship that we share is fundamental to our joint efforts to craft a successful budget which will safeguard the vulnerable beneficiaries of the programs that I just cited.

While we may share different perspectives in examining this budget, let us not overlook that there is some very basic agreement. I think some may tend to downplay this in light of news media publicity over the budget's more controversial provisions.

We are still sitting in this room today for the same purpose and we want to do what we can to foster the health and the well-being of the American public.

Certainly, that is the mission of the Department of Health and Human Services and I believe it is the mission of this committee as well.

We all face the same goal, and at the same time, we all face the same budgetary constraints. The President's budget is our plan to achieve the budgetary targets imposed by the Gramm-Rudman-Hollings law.

We recognize that you will not adopt this budget intact, nor do we expect that you will reject it in total. Instead, I hope you will receive this budget in the spirit in which it was crafted: it is our plan for promoting the Department's mission while achieving the mandated budgetary goal.

There is much talk about the budget driving health and social services policy. I would like to dispel that rumor today. There is no room for such an idea on my agenda as Secretary of Health and Human Services.

While it is true that we all face some very challenging budget targets, this budget highlights a solid core of commonsense provisions with worthwhile public policy goals. And before explaining them in some detail, let me briefly highlight three:

First, the infant health initiative. Foremost on my agenda are measures to improve the health status of our nation's children and reduce the alarming infant mortality rate in this country, a rate which persists despite our best efforts to the contrary. Consequently, I am proposing an infant mortality initiative under Medicaid to test the most effective case management techniques that we may have at hand to combat the problem.

Second, the private health plan option. This initiative which I will describe in more detail shortly, builds on four fundamental objectives that I am sure this committee endorses: reducing the government's direct role in medical and pricing decisions; and increasing choices for beneficiaries and providers; increasing competition among private organizations responsible for health care delivery; and increasing incentives for efficiency.

The greater opportunities through work, GROW, program is number three.

I am extremely enthusiastic about this proposal, which is aimed at enhancing the self-sufficiency of AFDC recipients who are likely to remain on welfare a long time. States will receive an open-ended funding at a 50 percent matching rate for necessary support services and other costs of GROW, excluding education and training which are funded by State and local governments and other federal programs. As envisioned by the Congress in its action on the 1987 budget, the current WIN and WIN Demonstration programs will be terminated, to be replaced by GROW.

And, finally, while it is not a formal part of the budget, let me note that our high priority for enactment this year will be the Medicare Catastrophic Illness Coverage Act.

Nothing poses more of a threat to the elderly than the fear of financially-devastating catastrophic illness. This legislation will provide peace of mind to our Medicare beneficiaries, a goal I know from my testimony last month that the committee shares.

Now, let me briefly present the highlights of our budget, and, with the chairman's permission, I will provide a more detailed description for the record.

Health proposals: infant health initiative. Mr. Chairman, there is nothing more tragic than lives lost needlessly and there is nothing

more frustrating to me as a physician and as Secretary of Health and Human Services than our infant mortality statistics. And despite our best efforts at all levels, there has remained nothing more elusive than a means to solve this problem.

The President's fiscal year 1988 budget reflects a major initiative to address this concern and to highlight our strong commitment to improving the health of this country's infants and reduce the alarming mortality rate.

We propose to create a special demonstration program under Medicaid to test the effectiveness of providing comprehensive case management services—educational, nutritional, and medical—for pregnant women and teenagers who are at high risk and who may have low birthweight babies.

We will give priority to States which can demonstrate effective and imaginative approaches to the problem. These demonstration projects will be coordinated with the delivery of services throughout other federal programs and will supplement on-going efforts under the material and child health block grant.

For fiscal year 1988, we are proposing a Medicare budget of about $73 billion. This represents a net increase over 1987 of 2 percent. With our reforms, we predict that Medicare still will grow at an average rate of nearly 8 percent over the next five years.

Our Medicare proposals have four themes: advancing the private health plan option; assuring quality health care; promoting increased competition and efficiency; and increasing beneficiary participation.

As this committee is well aware, Medicare first entered into risk contracts with health maintenance organizations and competitive medical plans on a broad scale in 1985. The private health plan option builds on this successful concept, allowing beneficiaries and providers broader opportunities to participate in Medicare through private health plans.

The expanded choice option would provide us with broad authority to contract with a wider array of private plans such as indemnity insurors and service benefit plans. We would pay these plans 95 percent of the projected cost of Medicare benefits in the fee-for-service system.

The employer-based plans option would permit these plans to assume responsibility for providing Medicare benefits to their retirees in exchange for a fixed government contribution.

Our budget intensifies the efforts currently underway to ensure quality of care for our beneficiaries. We will spend approximately $176 million on peer review organizations, our activities, refocusing the scope of work not only on utilization review but toward quality of care review.

Our components of this effort include: monitoring the quality of care provided to Medicare beneficiaries enrolled in HOMs and CMP plans; increasing funding for state survey and certification activities so that nursing home services are provided in facilities which meet the highest health and safety standards; and promoting a research budget which will fund quality of care-related studies.

Our budget also aims a number of proposals at refining the prospective payment system and reducing overpayments in services

still paid on the basis of costs. We also propose regulatory and statutory changes to repeal costly program expansions enacted last year in the Omnibus Budget Reconciliation Act of 1986.

Finally, the Medicare budget proposes modest increases in beneficiary cost-sharing. I understand, and share, the committee's reluctance to impose any hardship on our most vulnerable Medicare beneficiaries. However, I ask that you keep an open mind on this proposal. We will continue to believe that a modest level cost-sharing is a legitimate means of ensuring appropriate utilization of services without undue hardship for beneficiaries.

Between 1972 and 1982, Medicaid outlays grew at an annual rate of 14 percent. Through the joint action of the Congress and the Administration, we slowed that growth rate but increased program costs still face us. Under current spending projections, we anticipate an annual rate of growth of about 8.5 percent between 1988 and 1991, and this is three times the rate of general inflation.

Our fiscal year 1988 Medicaid proposals approach this problem from two perspectives: We suggest basic programmatic reforms which can increase access, promote efficiency, and improve quality; and we propose a series of growth limit and related initiatives.

Capitation provides incentives to deliver medical services with high quality. And while States can contract with prepaid plans under current law, provider capitation is not yet widespread in Medicaid. The core of this proposal would spur future growth by boosting the federal matching rate to help cover the increased costs associated with starting up new capitation projects.

Medicaid growth limit and related initiatives. In that area, we are resubmitting the proposal to limit the growth in federal Medicaid expenditures. At the same time, we propose to give States greater flexibility in meeting the ceiling through the opportunity to design and to operate their medical assistance programs in new ways. We are also proposing to eliminate the special matching rates under Medicaid.

Let me turn now to the human services portion of this budget.

One of my central priorities, as Secretary, is to strengthen the family and to ensure that our public institutions support, and not undermine, family life. Our legislative proposals for the child support enforcement and AFDC programs have two basic thrusts to enhance self-sufficiency: to increase payments by absent parents in support of their children and to increase work opportunities for custodial parents.

While States are in varying phases of implementing the 1984 child support amendments, we have not seen dramatic increases in collection levels or decreases in administrative expenditures. There is the need now for a greater stimulus to improve the effectiveness and efficiency of the child support enforcement program.

Our two major child support proposals will further emphasize cost-effective operations by requiring States' use of support-order guidelines to increase allocations and collections, and help prevent dependence on AFDC and/or Medicaid, and modifying the federal financing of the child support program.

I am particularly enthusiastic about our new work program proposal for AFDC recipients which is part of the President's "Trade

Employment and Productivity Act of 1987" and gives recipients the chance to achieve real self-sufficiency.

We all can agree that more attention needs to be focused on recipients who are likely to remain on welfare a long time: teenage mothers, who have their first child, and those who lack the basic education and work experience needed to become independent.

The GROW program would require most able-bodied adult recipients, including those with young children, to participate in activities leading to self-sufficiency. Teen-aged parents and dependent children aged 16 to 18 with less than a high school education will be required to participate in an educational program.

States will have great flexibility to design their programs based on local and individual needs and circumstances. Federal matching funds under the AFDC program will be available on an open-ended basis to cover 50 percent of the States' costs of operating the program, aside from education and training activities, including the necessary support services to include child care and transportation.

There is a major White House initiative in the area of welfare reform which certainly warrants your serious consideration.

In last year's State of the Union address, President Reagan charged his Domestic Policy Council to evaluate all government welfare programs, and develop a new strategy to promote "real and lasting emancipation" from welfare.

The results of this effort was the report titled "Up from Dependency: a new national public assistance strategy." It recommended the establishment of a program of wide-spread, long-term experimentation in welfare reform through community-based and State-sponsored demonstration projects.

The Department's new GROW initiative is consistent with the White House initiative as States will have great flexibility to design their work programs based on local and individual needs and circumstances.

The main focus of OHDS in 1988 will be to implement a broad social services strategy to target the most needy in our society. Along these lines, the fiscal year 1988 budget funds the State social services block grant at the full authorization level. And we request a generic appropriation of $2.2 billion for a wide array of social services programs in order better to focus resource allocation decisions on the overall direction of federal social services policy.

Our request for foster care and adoption assistance assumes enactment of a legislative proposal to limit State administrative costs and save $84 million without reducing the reimbursement payments made to families on behalf of foster and adopted children.

I would like to turn to the Administration's proposals related to Social Security, which include several proposals to expand Social Security coverage. These proposals would result in improved Social Security protection for agricultural and student workers, armed forces reservists, and certain individuals employed by relatives. Protection would also be expanded by conforming the Social Security treatment of group term life insurance to the income tax treatment.

Another proposal would require employers to pay Social Security taxes on tips, which would end the disadvantage to the Social Security Trust Funds which occurs because covered tips are used to

compute benefits but are not fully subject to Social Security employer taxes.

There is also a management improvement initiative that would modify the requirement for federal review of favorable State agency disability decisions in the Social Security disability insurance program.

There is no doubt that our budget poses a challenge. Since a full 96 percent is entitlements, you simply have to look at the program reforms in order to hold down spending to meet the Gramm-Rudman-Hollings targets.

This does not mean that we will sacrifice quality of care, that we will impose hardships on beneficiaries, or that we will toss deserving recipients off legitimate public programs. Not at all.

What this means it that we must look at how the programs are working, see what we can do to make them more efficient, to strengthen them, to hold down the rate of spending, and all the while preserve the mission of this, the people's department.

The message I want to leave with you is very simple, and that is that we really want to work with you. We want to avoid the concerns you have raised in the past about our inflexibility. We want, as do you, to foster the work of the Department of Health and Human Services.

The President's budget, submitted to you on January 5, represents the opening in what I hope will be a full and on-going dialogue. I pledge the resources of my Department and of my senior staff to work with you as we move together toward a closer examination of the proposals we have advanced.

Mr. Chairman, that concludes my oral remarks. And I will attempt to answer questions as you have them.

Senator MATSUNAGA. Senator Danforth has joined us. Senator, do you have an opening statement?

Senator DANFORTH. I have no opening statement, Mr. Chairman.

Senator MATSUNAGA. Mr. Secretary, as a proponent of the limited expansion of Medicare Part B coverage of occupational therapy services, which was enacted in the Omnibus Budget Reconciliation Act of 1986, and as the Senate sponsor of such legislation in the Ninety-eighth and Ninety-ninth Congress, I am dismayed at the Administration's proposal to repeal this and several other OBRA Medicare provisions.

I believe the occupational therapy provision will prove to save Medicare and other health care program expenditures in the long run by helping to ensure that patients are able to function independently after discharge, and by preventing rehospitalization.

I have noted that CBO projects savings of less than one-third of the savings projected by the Administration from the repeal of these provisions. Why such a large discrepancy between the Administration and the CBO, for one thing, and isn't it rather premature to judge these recently enacted provisions? Why not give them a chance to evaluate them, because these programs, especially the occupational therapy provision, was enacted with long-range savings in mind?

Secretary BOWEN. Mr. Chairman, our Department has no real evidence that the beneficiaries were not able to receive the necessary care prior to the enactment of the provider expansion that

was included in OBRA of 1986. Therefore, we have considered these expansions to be conducive to increased utilization and some duplication of the services.

Senator MATSUNAGA. The Director of OMB, Mr. Miller, said in his testimony before this committee on February 18, 1987, and I quote, "The Administration intends to promote competition, capitation and other reforms that rely on private markets to stimulate health care service efficiency and enhance the quality of care. As part of this effort, we plan to increase choices for beneficiaries and providers alike."

Now doesn't this repeal proposal contradict Mr. Miller's testimony?

Secretary BOWEN. I don't believe it does. For example, under the optometrist, the anount of care, or the care that the optometrists give has been available through the ophthalmologists, and also the physicians' assistants are supervised constantly by the physicians. So there would be actually a double payment there, one to the physicians' assistants and one to the physician for the supervision. So we really thought that there would be duplication and a tendency for overutilization, Senator.

Senator MATSUNAGA. Well, I cannot agree with you, Mr. Secretary.

Yes, Mr. Burke.

Mr. BURKE. There are initiatives that we are proposing, such as our private health plan option, that would lead to an enhanced array of options for beneficiaries, Medicare beneficiaries, who obtain. This initiative has been going on since 1985 and has been increasing the number of Medicare beneficiaries enrolling at a rate of about 7 percent a month. We are now looking at expanding that for employers to pick it up. Now employers, if they were to pick up this option and provide the care, or to the extent that Medicare beneficiaries opts to enroll in HMOs, they could, in fact, obtain these services. It is not inconsistent with the competition initiative at all.

We are just saying that we don't want to pay for them as a new entitlement when we have a trust fund which is heavily burdened. This is not the time to be putting on more bells and whistles. It just is not going to be able to take the added weight.

Senator MATSUNAGA. Senator Mitchell, do you have any questions?

Senator MITCHELL. Thank you, Mr. Chairman.

Let me just say that I share Senator Matsunaga's view regarding the repeal provisions, occupational therapy, and others, and would hope that we can get that behind us very quickly, Mr. Secretary.

I commend you again, as I did when you appeared here previously, on your proposal to deal with the problem of catastrophic illness.

One question that arises at the outset is, of course, the definition of "catastrophic," and you have defined it as $2,000 in out of pocket expenses. Well, that may be a catastrophy for most Americans. It surely is not for all Americans. A person who has an income of say $200,000 a year, a $2,000 medical bill may be an inconvenience, but it surely cannot be described as a catastrophy.

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That leads me to a question regarding that specific aspect of Medicare and Medicare in general. What is your view of making it in some form income-related, in the form of sliding scale deductibles, or perhaps placing a value on Medicare health benefits as inclusion for tax purposes so that we can, hopefully, provide more services for the same cost?

Secretary BOWEN. Well, I think that is a very legitimate area for discussion. The income relation will make the administration of it a lot more difficult. And as to the amount of extra cost that that would incur, I am not prepared to say. But the administration difficulties would be the main objection.

Senator MITCHELL. May I ask, but for the problem of administration—I recognize that it is a serious concern—do you oppose it in concept? Do you think it is wrong for the system to be income-related in some way?

Secretary BOWEN. No. I personally do not. It is my understanding that the majority of the senior citizens oppose it.

Mr. BURKE. Senator?

Senator MITCHELL. Mr. Burke.

Mr. BURKE. When Secretary Bowen first took office, and our budget not—the one we are testifying about this year, but last year's, we had proposed that, but it did not get there. Certainly the Department has not ruled that out. It is a very good idea, particularly again when we are facing the situation we are with the trust fund.

The problem we had in getting it built into the catastrophic proposal is we tried to keep it simple, and bringing in the means testing or income-relating the premium gets administratively very complex.

There were some issues there that were black boxes that we didn't have answers to. Where would we get the data, or where do you set the gaps? How do you graduate it? So this is an issue which we would not like to rule out, but we did not address it in the report.

Senator MITCHELL. Well, of course, one of the criticisms you got—you got it from both sides. It probably tells me you are on the right track—one of the criticisms you got from one side was that obviously the flat rate premium—I say, obviously—it is likely that the flat rate premium will tend to increase in the very near future. There will then be significant pressure on Congress not to permit the increase to occur, just as you know the original premium on Part B was intended to cover 50 percent of the cost. It is now 25 percent of the cost.

What are we going to do in five or 10 years when the burden of that increase becomes intolerable for those at the lower end of the income scale, and yet it appears that to do other than that will open up additional funding from general revenues? Did you consider any other means of financing? And are you concerned about the possibility of that premium rising rapidly to a point where it becomes a harsh burden on the low income person?

Secretary BOWEN. I am always very sensitive to what it will do to the low income person. And we chose the $2,000 level because we felt that that would be probably the proper level to keep the premium increase low, and yet the $2,000 level would not break

very many people. Those it would break are very close to the breaking point anyhow, and would be candidates for Medicaid.

Mr. BURKE. Senator, maybe I am a doubting Thomas, but I am not sure that there is evidence that will support your hypothesis that it will accelerate very rapidly. The catastrophic premium, as you know, is going to cover the co-insurance of hospital days beyond 60 where the people are very sick, starting getting hit with a larger and larger hospital co-insurance, and beyond 150 they are totally at risk.

Since the introduction of prospective payment, those days have, in fact, been declining. Should that continue to decline, that would have a break on the co-insurance rate, or the premium rate.

The other analogy you used of the Part B, Part B was never indexed. Ours is indexed, and had it been indexed it probably would not have fallen back down.

And the third thing in our budget, we do have a proposal to increase the 35 percent, the Part B premium, which would affect new people coming on line, because reducing, by and large, they are better off, and we would hold harmless those that are already on.

Senator MITCHELL. That is a tough problem for us.

Mr. Chairman, will we have additional rounds?

Senator MATSUNAGA. Yes.

Senator MITCHELL. I have several other questions. I thank you, gentlemen.

Senator MATSUNAGA. Senator Danforth.

Senator DANFORTH. Doctor, I read an article, believe it or not, in the Journal of the American Medical Association, a recent issue, and the article made the following point. It said that there is a limitation, or purported to have statistics, and made a real study to back this idea up. It said that there is a very severe limitation as to how far government can go in containing the cost of health care just by the prospective payment type of scheme. In other words, health care cost containment, viewed as reducing the number of days that a person spends in the hospital, is something that we have been working on. But according to the article, that does not have much more gas left in it.

And the article said that the real cost problem in health care is the explosion of technology, the availability of unprecedented and often very expensive ways of treating diseases, and the increased dispersal of those treatments throughout the population. For example, a heart transplant, I take it, is very, very expensive. There are a variety of different kinds of treatments that call for new technologies that are very expensive.

If the article is correct, it would raise serious ethical questions. And I am not sure how to answer those questions. To put it in a stark hypothetical form: Is there any limitation to what society can spend for health care for, somebody who has a life expectancy of one year?

Have you wrestled with this kind of problem? Is the article, as I have characterized it, presenting a reasonable concern? And if this is a concern, what, if anything, are we going to be doing to address it, or don't we know? I guess we don't know now.

Secretary BOWEN. You have touched on one of the most sensitive issues I think that is going to have to be decided by emphasis and Congressmen, I suspect, in the future.

I believe my figures are almost right, in that about one-third of all the expenditures of Medicare are done in the patient's last year of life. About another 20 or so percent, I believe, is in the last six months of life, and I think about 11 percent in the last 40 days of life. And that is at such a time when all of the——

Senator DANFORTH. Do you add those up? Are those all to be added up? Do you follow what I am talking about? I mean, is it 11 plus 20 plus 30?

Secretary BOWEN. No. The 33, I think, would take care of all of them.

Senator DANFORTH. Thirty-three would encompass all of them?

Secretary BOWEN. I believe that is so, yes.

In the last 40 days you do the heroic things to try to keep everyone alive. And I suspect that the feeling of most Americans are that they would not want to stop that. I think the answer to that would have to be getting a little more permission from the individual when he was well and of a sound mind to stating what he would like to have done—he or she would like to have done,—under circumstances where everything had been essentially done, and any more would only add to the misery and not doing anything but prolong the act of dying. That is a tough choice to make, but sometime in the future it probably will have to be made.

Mr. BURKE. In this connection, too, Senator, in 1983, the Boeing Commission recommended and endorsed the concept of living wills with some fanfare. At that time, there were 14 states that had living wills. I believe the number is now in the high 30s. This, as the Secretary said, is the vehicle that can be used to hold down those kinds of costs.

Secretary BOWEN. That is what I meant when I—I didn't make it very plain, but the individuals would have more say on what should be done to his future.

Senator DANFORTH. Does Medicare pay for things such as the heart transplants, artificial hearts? Would it pay for that?

Secretary BOWEN. The artificial hearts are still called experimental and they do not pay for those. But, yes, in the Medicare population, heart transplants just in this last, what, six months or so, has been authorized to be paid.

Senator DANFORTH. Do you know what the cost of an average heart transplant has been?

Secretary BOWEN. Someplace between 100 and 200 thousand dollars. I believe that is about right.

Senator DANFORTH. What is the most expensive treatment that a person can get now? Is it a heart transplant?

Secretary BOWEN. It would have to rank towards the top.

Senator DANFORTH. And if somebody is in that category and needs a heart transplant, they get it. And it would be a Medicare cost.

Secretary BOWEN. If they are in the Medicare group, that is right. There are not too many heart transplants above the age of 65, but there are those below the age of 65 who could still be under Medicare because of their disability.

Senator DANFORTH. Thank you, Mr. Chairman.

Senator MATSUNAGA. Chairman Lloyd Bentsen had intended to be here, but due to a long-standing commitment is unable to be here. But he will submit questions in writing to you, Mr. Secretary, and you may respond to his questions in writing for the record.

Secretary BOWEN. I would be happy to.

[The questions and answers follow:]

QUESTIONS FOR SECRETARY BOWEN FROM CHAIRMAN BENTSEN

1. Foster Care Independent Living Program - Last year, the Congress enacted the Independent Living program to help teenage foster care children as they move out of their foster care placements and into independent living arrangements. The law required the Department to issue regulations for this program within sixty days after enactment, and the Congress appropriated $45 million for this purpose for fiscal year 1987. The regulations have not yet been issued, and no money has been spent. Now, the Administration is proposing the repeal of the program altogether. Is the rationale for these actions budgetary savings, or are there policy reasons for refusing to implement this program? If Congress does not act on repeal legislation, by what date do you plan to issue the required regulations?

2. Limitation on Administrative Matching for Foster Care and Adoption Assistance - The President's 1988 budget includes a proposal to limit Federal matching for administrative costs of the foster care and adoption assistance programs. Administrative costs for these programs have risen considerably in recent years, and I understand that this may be a subject of concern. However, insofar as these increased expenditures reflect the provision of new and necessary services for foster care and adoptive children and their families, they would seem to be consistent with the goals of the Congress when it enacted the Child Welfare Amendments of 1980. Do you have convincing information that money that is being spent for administrative costs includes waste or abuse, rather than the legitimate provision of foster care and adoption services?

3. Administrative Reorganization - I understand that the Administration is considering the transfer of the foster care, adoption assistance and child welfare programs from the Administration on Children, Youth and Families to the new Family Support Administration. These three programs are of particular interest to me, because they involve services for the most vulnerable children in our society. In your opinion, would this proposed transfer improve the delivery of services under these programs, or might the foster care, adoption assistance and child welfare services programs actually be weakened as the result of being combined with programs (AFDC, WIN, and Child Support Enforcement) that have different goals and purposes? Why is not the Commissioner for the Administration on Children, Youth and Families the most appropriate administrator of these programs?

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United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

February 23, 1987

1. I recently received a response from Dr. Bowen regarding proficiency examinations for certain health professions. The letter stated that the Department supported repeal of the authority for the Clinical Laboratory Technologist Proficiency Examination. The Department intends to submit a proposal to repeal Section 9303 (b)(4) of the Consolidated Omnibus Budget Reconciliation Act. However, I understand that re¶repealing this Section of COBRA would not totally eliminate future exams. Would you proposing elimination of all authority for future Proficiency Examinations?

2. In regards to the Administration's catastrophic health insurance proposal, would you provide a list of the projected annual increase in the Medicare premium over the next five years to provide this coverage?

3. To follow-up on questions by Senator Danforth regarding the coverage of expensive technology, such as heart transplants, what procedures will be utilized to ensure that Medicare does not cover services? What will be the decision-making process to determine which services will be provided, and which services will be excluded from the Medicare catastrophic provision? Will Medicare contain an automatic gatekeeper device (such as the system in Great Britain which prohibits kidney dialysis after a certain age) which will require, for instance, that no one over age 62 shall receive a liver transplant?

4. Which services now provided by private sector Medigap insurance would be preempted by the catastrophic health insurance proposal? What usual and customary coverage would still be left to the private sector to offer under Medigap policies?

5. I recently sponsored a Senate Concurrent Resolution recommending that the Prospective Payment System for Radiologists, Anestnesiolgists, Pathologists not be implemented. I am concerned that we are trying to develop a PPS for physicians before we have an understanding of how it would work. Several studies are now underway on how to develop a Physician PPS for all doctors. Does it not make sense to wait until the studies have been completed before developing a prospective payment system, even one that applies to only hospital-based physicians?

6. Do you plan to expand experimentation with rural private health option plans under Medicare other than the Iowa demonstration? For instance, both Wyoming and Montana have had virtually no experience with capitation plans, largely due to their widely dispersed populations. Will there be an attempt to undertake a capitation demo in that region?

7. This country is often criticized for a high infant mortality rate compared to other industrialized nations. Do these countries use the same measuring techniques as used in the U.S. to track mortality? (For instance, at one point, many European nations did not count infant mortalities which occurred within a certain time frame after birth, while the U.S. did count such mortalities.)

8. On the question of welfare reform, is it possible to assign the same work requirements to the absent parent as are proposed for the custodial parent? Would such a work requirement increase child support collections and reduce welfare expenditures? What are the obstacles to requiring all four grandparents to assist with child support when the mother is a minor?

9. In order to improve child support collections, would you support a flat tax, for instance, 10% of AGI, on the absent parent to fund a child support benefit in place of AFDC?

Senator MATSUNAGA. I might also state for the record that Senator Heinz had intended to be here this afternoon, but due to a death in his family was unable to make it.

Now, Mr. Secretary, the Administration proposes to eliminate Medicare payments to hospitals for direct cost of nursing and allied health professional education. It is my understanding that Medicare makes payments for direct medical education costs for interns and residents, and for nurses and allied health professionals because these individuals provide services to patients, and because they represent additional costs to teaching hospitals which are not incurred by other hospitals.

As I mentioned in my opening statement, there is a nursing shortage in my State, and attempts are being made to expand nursing education to alleviate that shortage. I am concerned that this proposal will discourage essential nursing and allied health professional training because hospitals would lose money on these programs, and that the quality of patient care will suffer.

Was this proposal made by the Administration solely on budgetary grounds?

Secretary BOWEN. No, I don't think it was made solely on budgetary grounds. The initial Medicare legislation back in, what, 1965, did not require at that time the support of the various allied health training programs and nursing programs. And during the previous years when there was a shortage of physicians, Medicare then developed a policy to subsidize the training of additional personnel to include nurses in the medical system and allied personnel. And that was to assure that the beneficiaries would have services even if it were not through a physician at every time.

Recent studies, including the Jim Nack report of, what, two or three years ago, conclude that there is an oversupply of physicians at the present time. So Medicare, it seems, should no longer, or can no longer justify expenditures of a quarter of a billion dollars a year for the educational activities that are not deemed really to be necessary to meet the legislative mandates, nor assure the health care of all of the beneficiaries.

Senator MATSUNAGA. That may be so in the case of physicians, but I am referring to nurses. And as I understand it, there is a shortage of nurses not only in Hawaii, but throughout the nation. I would think that just as we come up with a program to meet the physician shortage that we would now continue this program with regard to nursing so that we would meet the shortage of nurses.

Secretary BOWEN. There is a question, I think, whether there is truly a shortage or nurses or a maldistribution of nurses. The number of graduates of nurses training and the baccalaureate degrees have gone up tremendously. I think that there are other reasons that there could be a shortage of nurses. One would be salary, and the other would be a shortage perhaps not in the total number of nurses, but in the specialities that are developing in the nurses' programs.

The method of graduating nurses have changed tremendously in the past several years from diploma type graduates from hospitals who train nurses. Now most of them receive the baccalaureate degree through regular colleges. And the opportunities also exist there for many, many scholarships. And also, I believe, the hospi-

tals themselves should have some responsibility towards training the types of specialty nurses that they need.

Senator MATSUNAGA. Do you have any figures as to how many nurses there are today and whether there is a maldistribution of them among the 50 States?

Secretary BOWEN. We can submit that for the record on the total numbers that are available.

Senator MATSUNAGA. I would appreciate that.

Secretary BOWEN. I am not sure we can be real accurate on the areas of just maldistribution that does exist. In some areas of need, the nurses may not be able, even though there may be an oversupply in one area, those nurses in that area may not be able to go to another area because their husband has a position and she cannot leave, or some other good reason. So the maldistribution problem, I think, is the big issue.

[The figures were not available at press time:]

Senator MATSUNAGA. If there is that condition today, we might institute some program to bring about a better distribution.

Secretary BOWEN. We have had HRA, or the Health Resources Administration, looking into that recently, and it is a tough one to tackle on getting individuals to move from one area to another, especially if there are family ties in one particular area.

Mr. BURKE. Senator, there is another important point to remember here with respect to medical education. When Medicare was passed, it was passed as a program of health care for the elderly. If you look at what has crept into Medicare, we pay now for a whole range of allied health professionals, medical pseudo-technologies, medical records people. In fact, in some 130 medical institutions in the United States, Medicare now pays more for the medical education component than we do for the care of the elderly that receive their care there.

Now considering the strains that the Medicare trust funds are under, these are logical candidates to be looked at for reducing.

And I would add too, a lot of training has very little to do with the care that Medicare beneficiaries receive. For example, pediatrics, obstetrics, we don't have an awful demand for pediatrics and obstetrics in the Medicare program, but we pay for their training.

Senator MATSUNAGA. Senator Mitchell?

Senator MITCHELL. Thank you, Mr. Chairman.

Dr. Bowen, I would like to go back to the catastrophic illness plan, and ask you specifically, did you consider other methods of enrollee-based financing? And if so, why did you select the fixed premium?

Secretary BOWEN. The alternative plan that was submitted would have increased the cost sharing for the up front cost. But that would have put a greater burden on just those who were ill rather than spreading it over the entire 30 million people, and would cause a greater burden on that particular group.

The good part, I think, about the $4.92 additional premium is it is hard to believe that someone wouldn't get that even if they were quite—or wouldn't get that much peace of mind out of their programs that they wouldn't have the rest of their savings totally wiped out. So the reason we favored that plan was it would not be

"taxing those who are sick for a greater portion of the funding it would take to fund the whole program."

Senator MITCHELL. And that would, in turn, escalate as the cost of inpatient care rose, if there were a percentage of the cost per day, let's say, 10 percent, those costs would be increasing each year so that anyone who uses the hospital would be confronted with increased cost sharing. And we also found that the fact is that only one person in four, one Medicare beneficiary in four uses a hospital, so those 25 percent will be providing the catastrophic cushion for everyone.

Senator MITCHELL. Yes.

Secretary BOWEN. I think another thing, it would have caused the Medigap policies to increase in price, it seems to me, because it would increase the amount of the front end cost that they would have to cover.

Senator MITCHELL. Did you consider the possibility that the catastrophic premium could in the near future rise at a rate greater than the Social Security cost of living adjustment? And if so, do you have a plan to deal with that situation when it arises?

Secretary BOWEN. Yes, we are aware of that. And I think the President has stated many times that he would not let anyone's Social Security check be reduced as a result of any increase in Medicare. And I think that that would be the solution. I don't think it would happen to very many individuals.

Senator MITCHELL. Well, what would happen to this program?

Mr. BURKE. In the legislation that we are submitting tomorrow we point out the hold harmless provision, and the only reservation we have is if the hold harmless provision is put in there, it has got to be put in in a budget neutral fashion.

Senator MITCHELL. But if this situation arises, where would the money come from to fund the program? If the premium necessary to cover the cost of the program exceeds the Social Security Cost of living adjustment, and you limit the increase to that amount, that creates an automatic assumption or inevitable conclusion that the program would be underfunded. Where would that balance come from?

Mr. BURKE. It could be an adjustment made on the $2,000 cap. That is one way of picking it up.

Senator MITCHELL. So there is nothing in the bill that specifically addresses that?

Mr. BURKE. No.

Senator MITCHELL. But you acknowledge that that could occur, and you take steps to limit the increase to the cost of living adjustment, and them would adjust, will address that at that time in terms of where we are going to get the extra money, or reduce the benefits?

Mr. BURKE. I think we pointed out to Congress and asked then that they may wish to address this in drafting the legislation. We are not specific in our bill.

Senator MITCHELL. Let me go on to a few other question areas. Mr. Chairman, interrupt me whenever my time expires.

Senator MATSUNAGA. Please go ahead.

Senator MITCHELL. While in the aggregate the prospective payment system has been effective in reducing overutilization of hospi-

tals, there appears to be growing evidence of serious problems in large inner city and small rural hospitals. My own State, as you know, is a rural State with a widely scattered population. Do you have any policy initiatives aimed at maintaining a role for the small rural hospitals in the delivery of health care in our society?

Secretary BOWEN. I guess having practiced in a rural hospital for a long period of time, I am very acutely aware of the problems. And I think this has been one of the issues that our health persons, HCFA has one of the toughest things that they have dealt with. There are a lot of different things that have been done to make sure that the rural hospital is treated fairly. And some of these, of course, are the fact that we have created the regional referral centers, where rural hospitals offer a comprehensive range of services and serve as regional resources so that they can be reimbursed at the urban rate.

We have created such things as——

Senator MITCHELL. What is the matter with just abolishing the differential?

Secretary BOWEN. Well, I suppose that is one possibility.

Mr. BURKE. Senator, that is how we proposed the legislation. Congress put the differential in.

Senator MITCHELL. So, can I say that you think that since you proposed it that way it would probably be a good idea?

Mr. BURKE. I will tell your colleagues.

Secretary BOWEN. Sole community hospitals have been created also, and there are over 360 of these, and they are paid a rate that is weighted heavily on their own financial experience. We have created what we call the outlyers. The separate outlyer offsets suburban and rural hospitals have been applied, and this results in less of a reduction to the standard payment rate per rural hospital.

Then the hospital market basket has been re-based and reweighted, and that has resulted in a reduction in the proportion of the standard payment rates which are labor related.

The swing bed option is another thing. In the hospitals below 50 beds, they could utilize part of the beds for a skilled nursing home facility or regular hospital beds, depending upon the need at the time.

I think also OBRA made some changes that would be effective. That is through the combined effect of the 1.15 percent update factor in the Reconciliation bill, and changes in the way that outlyer payments were financed, we estimate an increase in the federal payment rates to the rural hospitals to be about 3½ percent.

They also changed the way that the prospective payment system worked, and they are calculated from a hospital weighted to a case weighted average, which explains a little bit more in their favor.

It is getting a lot closer and it is a lot better, but we are continuing to monitor it. You have to remember that whatever you take off or give to the rurals, you are taking off of the urbans, and then we catch it from the other way.

Senator MITCHELL. Yes. Well, it is just like we change the tax about every 10 years to affect single and married taxpayers. It takes about 10 years for the cycle to catch up with us.

Doctor, I go home every weekend to meet with people who want to meet me, and just a week ago, unsurprisingly, I guess, I had a

large delegation of radiologists, anesthesiologists and pathologists at my office in Portland, Maine, who came from all over the State, and spent an hour or so telling me what a terrible idea this proposal is to reimburse them under the DRG system.

Do you really think this proposal is workable?

Secretary BOWEN. Senator, I don't think you should have been surprised that you had that visit.

Senator MITCHELL. Well, I have to tell you, I think very highly of you and say that, but, boy, they didn't have a nice thing to say about you, of a doctor doing this to his fellow physician.

Secretary BOWEN. I think you are quite aware that was not our first choice, the rearrangement.

Senator MITCHELL. Is it fair to say this is an OMB proposal?

Secretary BOWEN. Well, there is some justification. I would like to say that these———

Senator MITCHELL. Don't answer that. I don't want to put you in a tough spot.

Secretary BOWEN. All right.

Our proposal is simply to bundle the payments for the three. But there are some issues that we are agonizing over, and that is whether to pay the hospital or the physician group assignment of balanced billing options, appropriate update factors as the need arises, the possible adjustments for geographic locations, and whether the payments for the RAP services should be folded into the hospital DRGs or whether they should be made separately to the physician groups. We haven't come to a final decision on those.

Senator MITCHELL. We take that as an unenthusiastic defense of the proposal, Doctor.

Yesterday, the New York Times published a story, the lead paragraph, of which says, "An expert advisory panel created by Congress will soon recommend a standardized national fee schedule for payment of physicians who treat 31 million elderly and disabled people under Medicare, the federal health insurance program."

I would ask you, Doctor, do you favor or oppose such a proposal?

Secretary BOWEN. A fee schedule?

Senator MITCHELL. Yes.

Secretary BOWEN. Oh, I never liked the idea of schedules. But we have a study going on, I believe, with Harvard whose study is to be completed in 1988, on the relative value scale. And I think that the AMA has even been involved in helping to make that study. So I think that I would like to reserve my opinion on stating whether I would favor it or not until I see the results of that study.

Senator MITCHELL. Of that study, the one you referred to as opposed to this one? This is described as The Physician Payment Review Commission, to make its first annual report to the Congress next month.

Are we talking about two different studies?

Secretary BOWEN. Yes. Two different studies.

Mr. BURKE. That study is, I think, the product of the Physicians' Payment Assessment Commission, which is the equivalent of proPAC only for physicians. It is headed up by Paul Ginsberg. It is a creature of Congress. The study we are talking about is a relative value study that has been contracted with Harvard that has been going on now for I believe two years. It has one more year to run.

Senator MITCHELL. So may I take from your response that you have no position as of now on the question of a fee schedule, but rather wish to await the results of the Harvard study to which you refer, before making a decision, or taking a position?

Secretary BOWEN. I would prefer.

Senator MITCHELL. You would prefer that. All right. Well, at least you are not opposed.

I want to ask you about PROs. I noted you referred to that in your statement. As you know, on the last two reconciliation bills, Congress has expanded the scope of peer review to cover HMOs, and specified that the PROs focus more effort on quality assessment and assurance. Yet it appeared that the budget has made no provisions for funding of these additional activities.

Do you agree with my assessment of the situation, and, if so, what do you plan to do about it?

Secretary BOWEN. Funding will be provided in the new duties that they have been assigned. They have contracts and we will live up to the contract. If their contract calls for just doing so many things, and we have added to it, then we are going to add to the funding for them.

We are currently discussing the reprogramming of the funds to provide additional monies necessary to implement the requirements of COBRA and OBRA of 1986.

Our Inspector General has reported that the PRO profits are reasonable with their present functions. And, again, as we add new functions we certainly will reimburse them accordingly.

Senator MITCHELL. Let me ask you about another problem, and that is the increasing rate of denials of home visits under the Medicare home care benefit. Now, I, again on one of my weekly meetings in Maine, in fact, on several of them, I have met with large numbers of persons who document a sharp, a dramatic, a sudden increase in denials. And my question is, how is that defensible in the light of the efforts of your Department to encourage shorter hospital stays and lower nursing home utilization?

Secretary BOWEN. Let me first emphasize that we aren't trying to limit the provision of Medicare for the home health services. There are two issues that are involved. One is a general misconception of what type of home care Medicare covers, and the other is a belief that we are limiting the provision of care through increased denial.

First, the Medicare does cover home care only for patients who require a skilled level of care, and who are homebound, and who require only intermittant services. These requirements are spelled out in the law and they have been since the beginning of the program. But Medicare does not cover home health care for individuals who need assistance just for daily living.

There has been much discussion about the excessive or the inconsistent denial due to failure to meet the intermittant coverage criterion, and our review of the situation indicates that only about 1 percent of the denials are made on this basis. And to clarify the Medicare home health coverage, we are planning a series of training sessions with the people involved in the home health care agencies, especially on the homebound and on the intermittant requirements, and that is to be coordinated through our regional offices.

Second, it is true that the denial rate for home health bills has risen in the last year. In fact, it has risen from 3.5 percent in 1985 to 6 percent in 1986. But this increase, I am told, is largely the result of a number of improvements in administering the Medicare home health benefit which we had been directed to do so both by Congress and by GAO.

We have revised forms to collect uniform data to improve the medical review and payment coverage determination. I think that I am right in stating that home health care still is the fasted growing component of Medicare. So anything that is growing fast, we are always going to have some problems with. We are monitoring it, really.

Senator MITCHELL. And I appreciate it. It is a well prepared response. But you will never convince anybody in the field that this is anything other than a purely budgetary effort to shift costs onto the elderly. And I look forward to the results of that uniform data. Are you going to prepare some kind of a report based on that, or analysis, that we could have?

Secretary BOWEN. We will provide one.

Senator MITCHELL. Would you do that?

Secretary BOWEN. I don't know the time that we will have that completed, but we want to get it completed for our own sake as rapidly as we can and we will supply you with it.

Senator MITCHELL. All right.

[The information not available at press time:]

Senator MITCHELL. Mr. Chairman, may I continue or do you want to ask some questions? I have gone over my time, I know, and I would defer to you if you like.

Senator MATSUNAGA. I will ask a few questions, and then if you have more, I will come back to you.

Senator MITCHELL. All right.

Senator MATSUNAGA. Mr. Secretary, neither the President's budget nor your catastrophic proposal addresses the mental health benefits under Medicare. The caps of $250.00 per year in payments for outpatient mental health payments, and 190 days lifetime limit on inpatient psychiatric hospital services have never been increased since the inception of the Medicare program and they are not indexed.

I believe these limits, especially the outpatient cap, are unrealistic, and that beneficiaries are thereby being deprived of needed and appropriate care. While many private health plans also have limits on mental health benefits in order to control costs, their limits are generally higher than those in Medicare.

Do you have any comments on the status of Medicare mental health benefits?

Secretary BOWEN. I suspect I will have to prepare a written statement for you on that. I have no comments.

[The information not available at press time:]

Senator MATSUNAGA. Because as you well know, and I am sure you will agree with me, mental health is increasingly a major part of health, especially among the elderly.

Secretary BOWEN. Yes, sir.

Senator MATSUNAGA. And I would appreciate your response in writing.

The proposal to reduce the Medicaid matching rate from 90 percent to the regular State matching rate is linked to the Medicaid infant mortality initiative. Isn't this inconsistent: reducing the effort to prevent unwanted pregnancies, especially teenage pregnancies, while proposing to use the same funds to try to prevent premature births and treat low birth weight babies?

Secretary BOWEN. Well, I suspect it depends on how you look at it. I think that the programs that you are talking about that we want to get the $85 million from are already being—functioning well, and are in the States' programs. And we feel that when we match one program against the other that the infant mortality initiative is more important, and that we can get a lot more for the dollar doing this.

Even if Congress does not approve getting the $85 million by reducing the family planning's federal matching rate, we still want to do the infant mortality initiative and we are going to have to find another offset someplace in our budget to find the funds to do it. We are committed to the infant mortality initiative.

Mr. BURKE. Senator, the other thing to note is that we generally in the past have given high matching rates in the Medicaid program as a stimulus to the States to get programs on line. A good example is the Medicaid management information system, where we funded it at 90 percent, almost total federal funding, so the States would be able to put this system in place, so it would be to their benefit and to ours. We did the same thing here.

This program is now in place, and there is really no justification to keep the funding rate at that high level since we have reduced the Medicaid rate in other areas where half of the system has been picked up by the States and is operable for bringing the matching rate back down. They no longer need the incentive.

Senator MATSUNAGA. Well, I thought it appears really inconsistent to try to do one thing, on the one hand, and then another while we are operating to reduce it.

Shifting now to the Social Security program, Mr. Secretary, there is some sentiment expressed by members of Congress for changing the status of the Social Security Administration to that of an independent agency as a way to restore public confidence in the Social Security system. Now, what is your view on this proposal?

Secretary BOWEN. Well, I suspect I would agree with my predecessors, the Secretary of HEW, back then on HHS, both Republican and Democrat, who opposed the separation of SSA from the Department. I think that our opposition rests primarily on the grounds that making the Social Security Administration an independent would undercut the advantages to having the interrelated agencies within the same Department under the same departmental leadership.

Establishing SSA as an independent agency governed by a bipartisan board would, first of all, eliminate the Cabinet level representation that these 30 million people have, and I think should have. It would break up an integrated system of service delivery for income maintenance of family services and for the various health programs, and it would require expenditure of Social Security trust fund monies for duplicative and expensive payroll, personnel and

other support structures that are now, I think, operating pretty efficiently.

In my judgment, independent agency status cannot insulate SSA from political pressures either, and I think that was one of the aims for separation.

The same groups and the same elected officials would continue to play key roles in the development of Social Security policies.

I don't think it would even be desirable to insulate an agency which makes decisions affecting millions of people, and manages billions of trust fund dollars from the external influences and potential criticism. And because it is also such a large and critical program, Social Security, I think, should be accountable to the official elected by all of the people. I am talking about the President of the United States.

Finally, I think Social Security is in pretty good shape. And if it ain't broke, don't fix it. The problems with the programs have been resolved by legislation on financing and disability reviews, and the agency is in the best administrative condition than it has been for a good many years. The checks do go out to about 42 million people every month, pretty much of the right amount at the right time and at the right place. And I think the OASDI accuracy rate is right at a hundred percent; that the SSI is about 96 percent, and we are trying to get that up better.

The claims processing time is at an all time low. The average processing time for retirement and survivors insurance claims is now less than 21 days, and that is very, very good, I think.

The public also, in surveys, has given the SSA pretty high remarks on the quality of service, and that is according to a 1986 GAO survey. In fact, it said, "Four out of five persons rated the SSA service very good."

And we are in the midst of modernizing, and I think in the future by using telephone and computer technologies, that we will be able to provide service to the public even better and faster. So I really would not like to see it become an independent agency.

Senator MATSUNAGA. Senator Mitchell.

Senator MITCHELL. Boy, you were ready for that question. [Laughter.]

It is easy for us to get the staff to write questions. It is hard to get the staff to write answers before you come in here.

On the question of the special matching rate, aren't you concerned that the elimination of the special Medicaid matching rate for nursing home quality assurance activities could result in the deterioration of quality of care?

Secretary BOWEN. I see no reason why it should.

Mr. BURKE. We put some increased funds into the budget for quality assurance.

Secretary BOWEN. We have $176 million in the survey and certification program, and that is an increase in order to make sure that we are emphasizing quality of care, or the outcome, rather than all the light bulbs are in and whether there is a little dust in the corner, or something like that. We are emphasizing outcomes rather than facilities. That doesn't mean we are going to neglect facilities either.

Senator MITCHELL. Let me go on to another subject.

In your statement, you made reference several times to capitation. I would like to ask you to submit to me and to the other members of the committee any ideas you may have directed toward the subject of capability of HMOs to deliver, capitation plans, in rural areas. Growth, as you know, has occurred, for obvious reasons, in densely populated areas, and is just starting in a State like Maine. And there may be some things that have to be done to provide an incentive or encouragement to such plans going in there. Do you have any thoughts on that? If you want to wait, I would like to get a report in writing, whatever you say now.

Secretary BOWEN. There has been an HMO just recently, I believe, that started in rural Iowa. I think that is our first one in a rural area. And, of course, we want to make sure that we follow that to see how well they do. But you are right. And the HMOs usually go where they have the best opportunity, and the rural area charges usually are less than the urban areas, so that the competition for HMOs there would be a little more difficult. But we will try and get you an answer.

Senator MITCHELL. Thank you.

[The information follows:]

Senator MITCHELL. What do you think about merging Medicare Parts A and B?

Mr. BURKE. Well, we have moved a little bit in that direction in the catastrophic proposal in that we put the premium in to cover Part A. So we have bridged a little bit of the gap there.

Personally—I am not speaking for anybody but myself—I don't see anything inherently wrong with it. It corrects some administrative problems, in that you do have a small number who are Part A only, and don't take Part B, very few. It has been talked about. I haven't heard any compelling reasons why it couldn't be done.

Senator MITCHELL. Well, we had some testimony here a couple of weeks ago on that subject. I would like to send it to you and get your thoughts on that. That is something I think we should consider.

[The information not available at press time:]

Senator MITCHELL. Let me just say, in conclusion, I commend you particularly for an initiative in the area of infant mortality. I urge you to look at the experience in my own State where we had a very high infant mortality rate a decade ago, and through a concentrated effort, has now reached a point where the infant mortality rate in Maine is, I believe, the lowest in the nation. It may have slipped back to second in the past few months. That is something I have looked at. And what the State officials found in Maine was a really disturbing correlation between income level and infant mortality rate.

A child born of a poor family in America is three times as likely not to survive as a child born of a family that is not a poor family. And I think in our society that ought to be intolerable.

I commend you for the initiative. I pledge to you all the support that I at least can give, and I know other members of the committee would feel likewise. That is a very, very important area. It is absolutely disgraceful that our society has such a high national infant mortality rate when it is within our means to do something about it.

Secretary BOWEN. I agree. And let me add that the main reason for infant mortalities being up is the low birth weight. And the low birth weight, of course, can be associated with what you said. But also those who smoke and those who use alcohol, those who use drugs, those who have improper nutrition. And then we are facing another thing. Access to obstretical care is going to be another problem because of the obstetricians and family physicians not doing obstetrics any more because of the medical liability.

Senator MITCHELL. There also exists a correlation with family income and their incidence.

Thank you very much, Doctor. Thank you, Mr. Burke. We look forward to working with you.

Secretary BOWEN. Thank you, sir.

Senator MATSUNAGA. Senator Baucus, do you have any questions or statements you wish to make at this point?

Senator BAUCUS. Thank you very much, Mr. Chairman. Just a couple.

Mr. Secretary, what are we going to do to help rural hospitals? There were some provisions in the reconciliation last year that help. But as you well know, the Department promised the Congress to do a study to try to figure out the degree to which the differences between urban and rural DRGs should be eliminated. And as I recall, there was about a $600.00 per patient payment differential between urban and rural DRGs on the average. And that part of that differential, albeit a very small part, might be reduced because of some of the provisions that were passed last year. My understanding is that of the $600.00 differential, perhaps it might be lowered now to approximately $500.00.

In addition, as you well know, the cost to rural hospitals are going up very significantly, and I think at a rate faster than the cost to urban hospitals, in part, because the caseload of rural hospitals, I think, is declining even more; therefore, there is more volatility and fluctuation in cost to rural hospitals that they cannot make up, whereas, some of the other hospitals in various ways can.

Now we are not looking to give rurals a free ride, but we do want to iron out the differences in order to reduce that differential to the degree that that differential should be reduced.

My question is, when are we going to see the results of the Department's study, that is, the hard facts, not constant rhetoric, so that it is fair to both rurals and to urbans?

Secretary BOWEN. The differential has been considerably reduced, and we look forward to it being even reduced a little bit further. As I mentioned a while ago, what you give to the rurals comes off the urban, and then we catch it from the other side too.

Senator BAUCUS. I know you catch it from the other side. But if one is overpaid, you know, we want to do what is right around here.

Secretary BOWEN. Well, right in that we are trying to make things as even as we can.

In the Medicare world, there are a number of special provisions in the law right now which are of benefit to the rural hospitals and which will be increasingly of benefit. And some of them was just enacted last year, so that you are not going to have quite the full effect of it yet. Over changes, combine the effect of the 1.15 percent

update factor in the Reconciliation bill, and changes in the way that the outlyer payments are financed. And by that, we estimate an increase in the federal payment rates to rural hospitals of about 3½ percent. So I just don't think that they have realized that portion yet.

Oh, we have also changed the way that the PPS payments are calculated, from a hospital weighted to a case weighted average, and this could increase payments for rural hospitals by another 3 to 4 percent.

Another factor is the disproportionate share.

Senator BAUCUS. Mr. Secretary, I apologize. We all know that. What I am getting at is when--and I don't mean to hassle you; I am just asking a direct question—when will the Department send up the report that outlines the 1984 data? As I recall, the Department said it is waiting for the 1984 data before it could tell us the degree to which the urban-rural differential should be eliminated. And I am just wondering when we are going to get that. That is my question.

Secretary BOWEN. The urban-rural report, I am told, will be sent to Congress later this year, and it is supposed to come to my office soon. And by "soon," I hope, what?

Mr.Burke. It will be soon.

Senator BAUCUS. This year?

Mr. BURKE. You will have it shortly.

Senator BAUCUS. Can you give me just a rough idea? I am not going to hold you to it, but just basically when you plan to get it?

Mr. BURKE. Ninety days.

Senator BAUCUS. I am sorry.

Mr. BURKE. Not more than 90 days.

Senator BAUCUS. All right. That would be great.

Secretary BOWEN. Don't make me a liar, Tom. [Laughter.]

Senator BAUCUS. It also applies to sole community providers, as you know. Seventy-five percent of their payment is based on actual charges and 25 percent was DRG payment. I guess you said earlier, Mr. Secretary, that 75 percent is paid on actual charges, so that should help sole community providers.

As we all know though that that 75 percent is based upon 1982 data, and this is 1987. And, again, there is strong feeling that the costs have gone up more for some of these smaller sole community providers than it has for some other hospitals. So I am wondering what are we going to do about that? Will you study also be directed at sole community providers more specifically?

Secretary BOWEN. We would take in all rural hospitals.

Senator BAUCUS. I see my time is up, but if I might, Mr. Chairman, just a quick question here.

Senator MATSUNAGA. Yes.

Senator BAUCUS. What are we going to do when we enact the catastrophic health insurance this year when a lot of people—and let's assume it is basically the Administration's bill that is enacted—a lot of people who have Medigap coverage are going to be very, very confused. What is catastrophic going to cover? What Medigap coverage that they have to have? And so forth. I just anticipate a lot of confusion. How is the Department going to address that? I hope the Department doesn't oversell catastrophic health insurance.

A lot of seniors are going to think that catastrophic insurance is going to perhaps cover long-term care and perhaps cover prescription drugs. You know as well as I it can be very confusing to most folks as to what this is going to cover and they are going to wonder how far it will go.

How are you going to address that?

Secretary BOWEN. About two out of three of the senior citizens now feel that Medicare covers long-term care. And it never has. And, of course, we are going to start a massive educational campaign, working with the senior citizens, the AARP, and working with the private sector to educate the public just exactly what Medicare will cover and what it will not cover. I think that is the first step.

Senator BAUCUS. I don't know how you are going to do that if two out of three are confused right now. They will be more confused when this comes along. It sounds like your past programs haven't worked very well.

Secretary BOWEN. Well, it hasn't been the educational programs put forth like we are going to put.

Senator BAUCUS. What do you have in mind? What kind of programs?

Secretary BOWEN. Well, there will be a stuffer into the envelope where they receive their checks each month to advise them exactly what Medicare will cover and what it will not cover. And I think that will get to the 38 million people who receive these checks. Then work with the AARP, through their publications, to try to get articles written to be published there. They have a little weekly radio program that we will tell what it does cover and what it does not cover. We will use every means possible to do that.

Senator BAUCUS. Yes. I would just encourage you to be very, very imaginative and very creative, and spend a lot more time than you otherwise might on that. I expect it is going to be a very significant problem.

Mr. BURKE. Senator, we also have been contacted by, and will be meeting next week or this week, with the Health Insurance Association of America, working with them to launch an education campaign, so that we can come up with what is covered and what is not. In addition to that, the AARP has agreed to form a focus group that they will pilot test our stuffer on so that that will not go zap. It won't be an alarming thing to America's elderly. We will get the reaction back. We will go out with a good, informative piece of information to them.

We have a rather extensive education effort on several fronts that we hope will clear up some of the misconceptions out there. I know myself my father-in-law has three Medigap policies.

Senator BAUCUS. I encourage you to, as I said, not to oversell, not gild a lilly, because the more you do, the more it is going to come back and bite you. So I think that is the large part of it. Thank you.

Senator MATSUNAGA. Mr. Burke, this question is to you. As I understood you earlier in response to my question, you said that Medicare did not originally pay for direct medical education of nursing and allied health professionals. Am I correct?

Mr. BURKE. Yes, sir.

Senator MATSUNAGA. Well, I was curious about that because I was a cosponsor of the original Medicare bill as a member of the House, and so I had my staff check——

Mr. BURKE. Let me correct my statement, Senator. When Medicare was enacted it was not intended that Medicare pay these services. They were to be paid only until such time as alternative sources of funding could be found. They were never found.

Senator MATSUNAGA. Well, let me read to you from Senate Report number 404, Part 1, to accompany H.R. 6675, dated June 30, 1965. I quote: "Training of medical students, interns, residents, and the training of nurses and paramedic personnel enhance the quality of care. Until the community undertakes compensation of trainees, Medicare will cover these costs."

So you are right, they have not found the alternative. Until we do find such alternatives, which you may have in mind—I don't know whether you do or not—we ought to have Medicare continue to pay these costs.

Mr. BURKE. I wish I did, Senator.

Senator MATSUNAGA. One final question, Mr. Secretary.

With regard to Title 20 of the Social Security Act, funding for this social services block grant program has been constant at a level of $2.7 billion since 1984. As you know, the President's budget proposes to continue the $2.7 billion funding level. In constant 1987 dollars, this represents a reduction in funding of over 10 percent from 1984 to 1988. By 1980, the real decline, compared with 1984, will be 17 percent, according to my calculations.

Title 20 is a flexible source of funding which enable States to meet critical needs. This program has always been an important source of services for welfare recipients and could play an important role in welfare reform efforts by providing day care and other supportive services.

States also use Title 20 funds to provide services, including emergency temporary shelter for the homeless.

Now, shouldn't we consider increasing the funding level for this program?

Secretary BOWEN. It is a matter of choices. We have a bottom line that we have to meet, and this was our best estimate as to how we felt we should meet it and still not distract from any of the services. The choices are difficult when one's budget is 96 percent entitlement and 4 percent discretionary. So when we have to reach a bottom line we have to make some tough choices, and I would say this was one of the tough choices.

Senator MATSUNAGA. I am all for providing incentives—some way of making those on welfare become independent workers, providing for themselves. One of the ways in which we can do that, I think, is to provide for child care. I know of single parents, for example, who are unable to work because they are unable to pay for child care while they, usually mothers, are off to work. I am all for encouraging employers to provide day care centers right at the work place. I imagine that if the States were given some incentive to look into this matter of providing means to permit the single parent to work, such as providing day care centers, we would be moving in the right direction.

Secretary BOWEN. Our GROW program, or greater opportunities to work, does have day care and transportation into it. There is a 50-50 matching grant in our AFDC program for child care and transportation.

Senator MATSUNAGA. Did you have anything to add?

Secretary BOWEN. No.

Senator MATSUNAGA. Well, I want to thank you, Mr. Secretary, and Mr. Burke, for your patience. You have been here almost two hours. If we have any further questions, we will submit them to you in writing, and you may respond to the questions for the record in writing.

Secretary BOWEN. Thank you, Mr. Chairman.

Senator MATSUNAGA. Thank you ever so much. The committee stands in adjournment subject to the call of the Chair.

[Whereupon, at 4:18 p.m., the hearing was concluded.]

[The prepared written statement of Dr. Bowen follows:]

STATEMENT OF THE HONORABLE OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES

Good afternoon, Mr. Chairman and distinguished members of the committee. With me today is Tom Burke, my chief of staff.

I appreciate the opportunity to appear before you again, this time for the purpose of advocating the proposals in the President's fiscal year 1988 Health and Human Services budget which fall under the jurisdiction of the Finance Committee.

Mr. Chairman, your committee has jurisdiction over programs forming the very heart of the Department and affecting the lives of so many of this Nation's citizens, including: Medicare; Medicaid; Social Security; Aid to Families With Dependent Children, and supplementary security income.

In the past fourteen months, your membership has voted to confirm me as Secretary of Health and Human Services. You have approved my Under Secretary, the Administrator of the Health Care Financing Administration, and the Commissioner of Social Security. The special relationship we share is fundamental to our joint efforts to craft a successful budget which will safeguard the vulnerable beneficiaries of the programs I just cited.

While we may share different perspectives in examining this budget, let us not overlook that there is some very basic agreement. I think some may tend to downplay this in light of news media publicity over the budget's more controversial provisions.

We are all sitting in this room today for the same purpose: We want to do what we can to foster the health and the well-being of the American public.

Certainly, that is the mission of the Department of Health and Human Services, and I believe it is the mission of this committee as well.

We all face the same goal, and at the same time, we all face the same budgetary constraints. The President's budget is our plan to achieve the budgetary targets imposed by the Gramm-Rudman-Hollings law.

We recognize that you will not adopt this budget intact. Nor do we expect that you will reject it in total. Instead, I hope you will receive this budget in the spirit in which it was crafted. It is our plan for promoting the Department's mission while achieving the mandated budgetary goal.

There is much talk about the budget driving health and social services policy. I wish to dispel that rumor today. There is no room for such an idea on my agenda as Secretary of Health and Human Services.

While it is true that we all face some very challenging budget targets, this budget highlights a solid core of commonsense provisions with worthwhile public policy goals. Before explaining them in some detail, let me briefly highlight three:

The infant health initiative: Foremost on my agenda are measures to improve the health status of our Nation's children and reduce the alarming infant mortality rate in this country—a rate which persists despite our best efforts to the contrary. Consequently, I am proposing an infant mortality initiative under Medicaid to test the most effective case management techniques we may have at hand to combat the problem.

The private health plan option: This initiative, which I will describe in more detail shortly, builds on four fundamental objectives I am sure this committee endorses: Reducing the Government's direct role in medical and pricing decisions;

Increasing choices for beneficiaries and providers; increasing competition among private organizations responsible for health care delivery; and increasing incentives for efficiency.

The greater opportunity through work [GROW] proposal: I am extremely enthusiastic about this proposal, which is aimed at enhancing the self-sufficiency of AFDC recipients who are likely to remain on welfare a long time. States will receive open-ended funding at a 50-percent matching rate for necessary support services and other costs of GROW, excluding education and training which are funded by State and local governments and other Federal programs. As envisioned by the Congress in its action on the 1987 budget, the current WIN and WIN demonstration programs will be terminated, to be replaced by GROW.

And finally, while it is not a formal part of the budget, let me note that our high priority for enactment this year will be the Medicare Catastrophic Illness Coverage Act.

Nothing poses more of a threat to the elderly than the fear of financially-devastating catastrophic illness. This legislation will provide peace of mind to our Medicare beneficiaries—a goal I know from my testimony last month that the committee shares.

Now, let me briefly present the highlights of our budget, and, with the Chairman's permission, I will provide a more detailed description for the record.

HEALTH PROPOSALS

Infant health initiative: Mr. Chairman, there is nothing more tragic than lives lost needlessly. There is nothing more frustrating to me as a physician and as Secretary of Health and Human Services than our infant mortality statistics. And, despite our best efforts at all levels, there has remained nothing more elusive than a means to solve this problem.

The President's fiscal year 1988 budget reflects a major initiative to address this concern and to highlight our strong commitment to improving the health of this country's infants and reducing the alarming mortality rate.

We propose to create a special demonstration program under Medicaid to test the effectiveness of providing comprehensive case management services—educational, nutritional, and medical—for pregnant women and teenagers who are at high risk and who may have low birthweight babies.

We will give priority to States which can demonstrate effective and imaginative approaches to the problem. These demonstration projects will be coordinated with the delivery of services throughout other Federal programs and will supplement ongoing efforts under the maternal and child health block grant.

Medicare: For fiscal year 1988, we are proposing a Medicare budget of about $73 billion. This represents a net increase over 1987 of two percent. With our reforms, we predict that Medicare still will grow at an average rate of nearly eight percent over the next five years.

Our Medicare proposals have four themes: Advancing the private health plan option; assuring quality health care; promoting increased competition and efficiency; and increasing beneficiary participation.

Advancing the private health plan option as this committee is well aware, Medicare first entered into risk contracts with health maintenance organizations [HMO's] and competitive medical plans [CMP's] on a broad scale in 1985. The private health plan option builds on this successful concept, allowing beneficiaries and providers broader opportunities to participation in Medicare through private health plans.

The expanded choice option would provide us with broad authority to contract with a wider array of private plans such as indemnity insurers and service benefit plans. We would pay these plans ninety-five percent of the projected cost of Medicare benefits in the fee-for-service system.

The employer-based plans option would permit these plans to assume responsibility for providing Medicare benefits to their retirees in exchange for a fixed Government contribution.

Assuring quality health care: Our budget intensifies the efforts currently underway to ensure quality of care for our beneficiaries. We will spend approximately $176 million on peer review organization [PRO] activities, refocusing the scope of work not only on utilization review but toward quality of care review.

Other components of this effort include: Monitoring the quality of care provided to Medicare beneficiaries enrolled in HMO and CMP plans; increasing funding for State survey and certification.

Activities so that nursing home services are provided in facilities which meet the highest health and safety standards; and promoting a research budget which will fund quality of care-related studies.

Promoting competition and efficiency: Our budget also aims a number of proposals at refining the prospective payment system and reducing overpayments in services still paid on the basis of costs. We also propose regulatory and statutory changes to repeal costly program expansions enacted last year in the Omnibus Budget Reconciliation Act of 1986.

Increasing beneficiary participation: Finally, the Medicare budget proposes modest increases in beneficiary cost-sharing. I understand—and share—the committee's reluctance to impose any hardship on our most vulnerable Medicare beneficiaries. However, I ask that you keep an open mind on this proposal. We continue to believe that a modest level cost-sharing is a legitimate means of ensuring appropriate utilization of services without undue hardship for beneficiaries.

Medicaid: Between 1972 and 1982, Medicaid outlays grew at an annual rate of fourteen percent. Through the joint action of the Congress and the administration, we slowed that rate of growth. But increased program costs still face us. Under current spending projections, we anticipate an annual rate of growth of about eight point five percent between 1988 and 1992. This is three times the rate of general inflation.

Our fiscal year 1988 Medicaid proposals approach this problem from two perspectives: We suggest basic programmatic reforms which can increase access, promote efficiency, and improve quality; and we propose a series of growth limit and related initiatives.

Reform Medicaid through capitation: Capitation provides incentives to deliver medical services with high quality. While States can contract with prepaid plans under current law, provider capitation is not yet widespread in Medicaid. The core of this proposal would spur future growth by boosting the Federal matching rate to help cover the increased costs associated with starting up new capitation projects.

Medicaid growth limit and related initiatives: We are resubmitting the proposal to limit the growth in Federal Medicaid expenditures. At the same time, we propose to give States greater flexibility in meeting the ceiling through the opportunity to design and operate their medical assistance programs in new ways. We are also proposing to eliminate the special matching rates under Medicaid.

HUMAN SERVICES

Let me turn now to the Human Services portion of this budget.

Family support: One of my central priorities as Secretary is to strengthen the family and to ensure that our public institutions support, not undermine, family life. Our legislative proposals for the child support enforcement and AFDC programs have two basic thrusts to enhance self-sufficiency—to increase payments by absent parents in support of their children and to increase work opportunities for custodial parents.

While States are in varying phases of implementing the 1984 child support amendments, we have not seen dramatic increases in collection levels or decreases in administrative expenditures. There is the need now for a greater stimulus to improve the effectiveness and efficiency of the Child Support Enforcement Program.

Our two major child support proposals will further emphasize cost-effective operations by (1) requiring State's use of support-order guidelines to increase allocations and collections and help prevent dependence on AFDC and/or Medicaid and (2) modifying the Federal financing of the child support program.

I am particularly enthusiastic about our new work program proposal for AFDC recipients which is part of the President's "Trade Employment and Productivity Act of 1987" and gives recipients the chance to achieve real self-sufficiency.

We all can agree that more attention needs to be focused on recipients who are likely to remain on welfare a long-time—teenage mothers who have their first child and those who lack the basic education and work experience needed to become independent.

The GROW Program would require most able-bodied adut recipients, including those with young children, to participate in activities leading to self-sufficiency. Teen-aged parents and dependent children aged 16 to 18 with less than a high school education will be required to participate in an educational program.

States will have great flexibility to design their programs based on local and individual needs and circumstances. Federal matching funds under the AFDC Program will be available on an open-ended basis to cover 50 percent of the States' costs of operating the program, aside from education and training activities, including the necessary support services such as child care and transportation.

White House welfare reform: There is a major White House initiative in the area of welfare reform which certainly warrants your serious consideration.

In last year's State of the Union address, President Reagan charged his Domestic Policy Council to evaluate all Government welfare programs and develop a new strategy to promote "real and lasting emancipation" from welfare.

The result of this effort was the report titled "Up From Dependency: A New National Public Assistance Strategy." It recommended the establishment of a program of wide spread, long-term experimentation in welfare reform through community-based and State-sponsored demonstration projects.

The Department's new GROW initiative is consistent with the White House initiative as States will have great flexibility to design their work programs based on local and individual needs and circumstances.

Human development services: The main focus of OHDS in 1988 will be to implement broad social services strategy to target the most needy in our society. Along these lines, the fiscal year 1988 budget funds the State social services block grant at the full authorization level. We request a generic appropriation of $2.2 billion for a wide array of social services programs in order to better focus resource allocation decisions on the overall direction of Federal social services policy.

Our request for foster care and adoption assistance assumes enactment of a legislative proposal to limit State administrative costs and save $84 million without reducing the reimbursement payments made to families on behalf of foster and adopted children.

Social Security: I would like to turn to the administration's proposals related to Social Security, which include several proposals to expand Social Security coverage. These proposals would result in improved Social Security protection for agricultural and student workers, Armed Forces Reservists, and certain individuals employed by relatives. Protection would also be expanded by conforming the Social Security treatment of group term life insurance to the income tax treatment.

Another proposal would require employers to pay Social Security taxes on tips, which would end the disadvantage to the Social Security trust funds which occurs because covered tips are used to compute benefits but are not fully subject to Social Security employer taxes.

There is also a management improvement initiative that would modify the requirement for Federal review of favorable State agency disability decisions in the Social Security Disability Insurance Program.

CONCLUSION

There is no doubt that our budget poses a challenge. Since a full 96 percent is entitlements, you simply have to look at program reforms in order to hold down spending and meet G-R-H targets.

This does not mean that we will sacrifice quality of care, that we will impose hardships on beneficiaries, or that we will toss deserving recipients off legitimate public programs. Not at all.

What this means is that we must look at how the programs are working, see what we can do to make them more efficient, to strengthen them, to hold down the rate of spending, and all the while preserve the mission of this, the people's department.

The message I want to leave with you is very simple. We want to work with you. We want to avoid the concerns you have raised in the past about our inflexibility. We want, as do you, to foster the work of the Department of Health and Human Services.

The President's budget, submitted to you on January 5, represents the opening in what I hope will be a full and on-going dialogue. I pledge the resources of my Department and of my senior staff to work with you as we move together toward a closer examination of the proposals we have advanced.

Mr. Chairman, this concludes my oral remarks. I will be pleased to answer any questions you may have.

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