S. HRG. 104-791

GOVERNORS' PROPOSAL ON WELFARE AND MEDICAID

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

ON THE

NATIONAL GOVERNORS' ASSOCIATION POLICY ON WELFARE REFORM AND MEDICAID (WITH ADMINISTRATION AND PUBLIC VIEWS)

FEBRUARY 22, 28, AND 29, 1996

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CONTENTS

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

COMMUNICATIONS

GOVERNORS' PROPOSAL ON WELFARE AND MEDICAID

THURSDAY, FEBRUARY 22, 1996

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

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

Present: Senators Chafee, Simpson, Hatch, Nickles, Rockefeller, Breaux, Conrad, and Gramm.

Also present: Connie Binsfeld, Lieutenant Governor, State of Michigan.

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

The CHAIRMAN. The committee will please be in order.

I would like to begin by outlining how we will proceed with today's hearing. I know the members will have plenty of questions for the Governors, and I do want to allow as much time as possible to explore the details of their proposal. Therefore, I have a short statement.

Unfortunately, Senator Moynihan got fogged out, so he will not be here today. But he does have a statement, which will be included as part of the record.

I am going to ask the other members to refrain from making statements so that we can get right to the questions.

First of all, let me start out by thanking all the Nation's Governors. It is particularly a pleasure to have our Governor from Delaware here, as well as the others.

Again, let me express my appreciation for the extraordinary contribution you have made, which I think has rekindled the hope of achieving Medicaid and welfare reforms this year.

All of the men and women who serve as the chief executives of our 50 States deserve our thanks and congratulations for presenting the American people with this unanimous bipartisan proposal.

The gentlemen whom we welcome before the committee today have, I think, earned special recognition for their efforts. Before us today are Governors Carper, Chiles, Engler, Miller, Romer, and Thompson; along with Governor Mike Levitt, who truly created this proposal when few believed that it was possible.

The Governors are here today because they realized their task was not completed on February 6th when they unanimously approved their bipartisan resolutions on Medicaid and welfare reform.

Nor does their work end with today's hearing. I know you recognize that there is still much work to do in translating the 10 pages of the resolutions into a comprehensive legislative package. There are tough questions which must be answered, for Republicans and Democrats alike.

On the major welfare issues, the NGA work reflects the fundamental changes to the welfare system advanced by H.R. 4, the Personal Responsibility and Work Opportunity Act of 1995. The NGA proposal demonstrates that we have been on the right approach, the right track. The Governors' proposal on Medicaid reminds us that Medicaid reform is welfare reform.

Medicaid is the Nation's largest welfare program and each year it costs more than the AFDC program, food stamps, and Supplemental Security Income program combined. As such, Medicaid must take its place in the efforts to end the cycle of dependency for the millions of American families and children now trapped in the welfare system.

The current Medicare and welfare systems are ladened with perverse incentives. All too often we hear that poor families cannot afford to leave the welfare system, and, therefore, Medicaid must be part of the solution for returning families to work.

If we succeed in reforming our welfare programs, I believe one of the most exciting developments we will witness is how the States will use the power of Medicaid dollars to expand health insurance coverage for more working families, even while slowing the rate of growth and the cost of the program.

The work of the Governors means a fresh start for the Congress and the President. They have given us bold proposals, strengthened by unanimous consent. I look forward to working with each of the Governors, as well as my colleagues on the committee, individually and collectively, to deliver the authentic welfare reform the American people need and expect.

Now, as I mentioned, we will include Senator Moynihan's statement in the record as if read.

Senator ROCKEFELLER. Could I ask that my statement be included as if read?

The CHAIRMAN. Without objection, so ordered.

[The prepared statements of Senators Moynihan and Rockefeller appear in the appendix.]

The CHAIRMAN. All statements of members will be included as if read.

I would like the Governors to limit their testimony today to 5 minutes each, then members will have 5 minutes for questions. We will have as many rounds of questions as we need.

Questions can be addressed to the Governors on both Medicaid and welfare, but I would urge each of the members to concentrate your early questions on welfare because Governor Carper has to leave early, and I know we want to have his full advice.

So if that is satisfactory, I would now like to call on the Co-Chairmen of the National Governors' Association, Governor Thompson and then Governor Miller.

Governor Thompson?

STATEMENT OF HON. TOMMY G. THOMPSON, GOVERNOR OF THE STATE OF WISCONSIN, AND CO-CHAIR, NATIONAL GOVERNORS' ASSOCIATION

Governor THOMPSON. Thank you very much, Chairman Roth. Let me just state for the record, it is truly an honor for all of us as Governors, Democrats and Republicans alike, to have this opportunity to appear in front of you and to thank you for your leadership, and to thank the membership of this committee for giving this opportunity to display what we think is a workable plan, a bipartisan plan.

I would like to also point out for the record that six Governors, Levitt, Romer, Chiles, Engler, Miller and Thompson, have spent over 100 hours here in Washington, D.C. since the week before Christmas, working on our Medicaid plan, and I believe not that much time, but a lot of time, by Governors Carper and Engler on welfare. We have been able to come together in a bipartisan way, and all of our proposals were passed unanimously on February 6th.

I also would like to point out for the members, we were able to make a lot of progress—maybe it is something that the Senators could utilize when they are discussing Medicaid and welfare—after we decided we would not use the buzz words "individual entitlements" or "block grants." We found when we used those words it was a polarizing kind of thing and we were not able to make much progress, so we called them Program X and Plan Y. With that, we have made a lot of progress, and that is why we are here today.

I thank you, Mr. Chairman and members. We appreciate this opportunity to appear before you to present the National Governors' Association policy on welfare reform and Medicaid.

Recently, the Nation's Governors came together on a bipartisan basis, Republicans and Democrats working together, to address two very difficult issues: welfare reform and Medicaid. We came together because these issues are simply too important to be left unresolved.

These are programs that currently are not effectively serving the people they are intending to help, nor are they serving the interests of the taxpayers who generously pay for them. We need to change these programs for the better, and the Governors' plan, we believe, accomplishes that goal.

Our plan is a compromise, a strong bipartisan compromise, that will effectively move people on welfare into work, as well as provide the elderly, the disabled, and poor with more efficient, quality health care.

Our plan provides States with the flexibility which we need so badly to design programs that will best serve the unique needs of the people of their States, while maintaining guarantees for the most vulnerable populations.

If given the opportunity, Governors will design programs in their States that will better serve those in need and make sure that the taxpayers' dollars are being spent in a more effective manner.

All across this country the States have proven that they can, and have been, moving people from welfare into work. States are prov-

ing they are much more capable of providing quality health care for the elderly, the disabled, and the poor.

As Governors, we know how to make these programs work, for we are the ones charged by the Federal Government for running these programs. What we all know as Governors, is a very true axiom. That is, one size does not fit all. What works for the people of California may not work for the people of Wisconsin, and what works for the people of Wisconsin may not work for the people of Michigan or Florida.

Make no mistake about it; if you give States the flexibility to design their own programs on welfare and Medicaid, you will spark a spread to the top, not the bottom. You will see Governors trying to outdo each other in designing programs that best serve the people of their State.

Governors will work to liberate more families from welfare and poverty. They will work to provide more efficient and more effective health care to the elderly and the poor. We are already doing this under the very limited circumstances allowed by the current waiver system. Rest assured, no Governor is going to let a child or a family go without adequate food, medical care, or shelter and it is flat-out wrong for anyone to suggest otherwise.

Therefore, the Governors believe that it is critical that Congress pass, and that the President sign, the three major bills of welfare reform, Medicaid, and employment and training during the next month. States must have the flexibility to integrate these three programs in order to provide cost-effective services that assist in moving people from welfare to work.

The window of opportunity is very small. Shortly you will begin the budget process for fiscal year 1997. Failure to act now means that any reform is unlikely to occur for 2–3 years because of the election year.

You have to realize that we spend, on average, 25–30 percent of our money on these programs. The failure of Congress and the President to move forward will cause major problems in a number of States.

The bottom line, is that everyone agrees that the current welfare system is broken, the current Medicaid system is inefficient. The Governors, in a unanimous, bipartisan manner, have developed a plan that improves on these programs and better serves the people of the country.

Thank you, Mr. Chairman and members. I appreciate your support. Now I would like to ask Governor Miller, the vice chairman, to take over.

[The prepared statement of the National Governors Association appears in the appendix.]

The CHAIRMAN. Governor Miller, we look forward to hearing from you.

STATEMENT OF HON. BOB MILLER, GOVERNOR OF THE STATE OF NEVADA, AND CO-CHAIR, NATIONAL GOVERNORS' ASSOCIATION

Governor MILLER. Thank you, Mr. Chairman, distinguished members. We appreciate the opportunity for myself and my col-

leagues to be here today to discuss outlines for these two important proposals.

As we begin the dialogue today on the Governors' proposals to reform both Medicaid and welfare, I would like to emphasize the strength and desire we encountered with our colleagues who truly want to see both of these programs and the systems by which they are administered change.

As an association, we have spent the last 6 months working out our differences, identifying principles in order to reach consensus positions on these two issues.

As Chairman Thompson stated, this is a unique time and opportunity for Governors. We are faced with maintaining a responsibility, a firm guarantee of health care to citizens who are in need. At the same time, as the fiscal managers of our State governments, we are acutely aware of the ever-mounting cost of providing this care.

The sheer mathematics of the Medicaid program have driven us to work together to address reform measures. We, as Governors, have watched as Medicaid costs have consumed an inordinate share of State budgets, and it is not too fine a point to say that these costs have forced us to make very difficult budgetary decisions.

Governor Thompson and I made a commitment to each other that we would attempt to find a bipartisan consensus on restructuring Medicaid and welfare. After hours of seemingly endless discussions and heated debate, we, along with Governors Chiles, Levitt, Romer, and Engler on Medicaid, and Governor Carper on welfare, were successful in drafting a proposed framework, a blueprint if you will, that would provide the Congress and the administration a road map to a potential reform of these programs.

It is also my sincere hope that Medicaid, if it has been a stumbling block in the budget negotiations, could have been removed to a modest step in helping you here in Washington resolve that even bigger problem. It is testimony to the hard work of my colleagues that, despite these differences and the difficult nature, this program and outline has been unanimously supported by our colleagues in early February.

This compromise—and it is a compromise—is built on four primary principles related to Medicaid. First and foremost, both States and the Federal Government must keep their commitment that health care coverage will be guaranteed for this country's most vulnerable citizens.

This includes pregnant women and children under 6 with incomes under 133 percent of poverty; children ages 6 to 12 in families with incomes up to 100 percent of poverty; and it also includes the elderly and the disabled. The growth in health care expenditures must be brought under control.

Nationally, Medicaid costs have grown well in excess of 10 percent per year, sometimes approaching 20 percent. In Nevada, the increases have been even more dramatic. From less than $185 million in 1991, Nevada's Medicaid costs have grown to nearly $450 million in 1995, a short four years. This represents an astounding growth of 25 percent per year.

We believe the current Medicaid program is overly burdened with years of Federal regulations that have hamstrung States' ability to provide health care to those in need. Compounding this problem is the process States must go through in order to design or improve new systems for providing service.

The administration should be complimented for the strides it has made in reducing the bureaucratic obstacle course, but current law restricts its ability to go further. We ask for your assistance in granting States the necessary flexibility to provide more effective and efficient delivery of service.

Last, States must be protected from unanticipated program costs resulting from business cycle fluctuations, changing demographics, or natural disasters. In other words, the Federal Government must remain our permanent partner in guaranteeing health care coverage. Without this insurance, States will not be able to meet our commitment when the case loads swell because of unanticipated events.

On a personal note, I can tell you firsthand how important this last principle is. In Nevada, we have experienced tremendous economic growth and a booming population as people from all over the country move into our State.

That is good news, but there is a consequence of this growth. Combined with an economic downturn, it would be an unmanageable increase in Medicaid costs beyond the 25 percent we are already experiencing, and that would spell financial disaster for us without shared Federal and State responsibility.

In sum, I believe we have provided you a possible bridge whose structure is based upon maintaining an unwavering guarantee to our citizens, unprecedented flexibility to States to manage the program, and a funding mechanism that protects against economic storms and demographic changes.

I do not doubt that our program can be improved upon. Indeed, we believe that much of the detail needs to be worked out. But I do want to underscore that this is a compromise, and the balance we struck is a delicate one. To stray too far from its fundamental principles would be to risk an unraveling of even our agreement.

We hope and we know that to move forward from this plan to an actual law, bipartisanship must be the watchword, the compass to guide us all. Thank you.

The CHAIRMAN. Thank you, Governor Miller.

Next, I will call on the Co-Chairmen of the Welfare Task Force, Governor Carper and Governor Engler.

STATEMENT OF HON. JOHN ENGLER, GOVERNOR OF THE STATE OF MICHIGAN

Governor ENGLER. Thank you, Mr. Chairman. I am delighted for the opportunity you and the members of the Finance Committee have given us, in letting the Nation's Governors testify before your committee.

I want to pay special note to the two Governors who have just spoken, Chairman Thompson and Vice Chairman Miller. Their commitment to welfare reform and their dedication to reaching a bipartisan resolution to this issue has been critical, and they have

been extremely supportive of the work that has been done by Governor Carper and myself.

I also would note the presence in the audience today of the Lieutenant Governor of the State of Michigan, Connie Binsfeld, who is in the second row. I am delighted she could join us as well. It is that important to Michigan, that we have both of our top two leaders here.

The proposal that I am here today to present is a solid step forward and it lays the groundwork for future progress. Certainly there has been an expression by some that the protections afforded by the status quo will be lost as States engage in a headlong rush to the bottom, cutting benefits, slashing coverage.

America's Governors are offended by that completely unfounded, unsubstantiated charge. What the defenders of the status quo must admit is that the current system is a system that has failed people, that holds people on the bottom.

Mr. Chairman and committee members, when it comes to welfare reform the NGA proposal defines the middle ground, but it is definitely not middle-of-the-road. It represents the fast lane to responsibility and independence for at-risk families.

Just consider the Washington Post headline describing what the Governors' policy—adopted unanimously with the support of our most conservative and most liberal Governor and everybody in between—meant.

The Post headline read, "Governors' reform plan would break with 60 years of policy." Remember, what the Governors propose is changing a law that has been the basis of Federal policy for 60 years, and remember how counterproductive these policies have been.

They punish parents who work too much, they punish mothers and fathers that want to stay together, they punish working families who save money, they reward teenagers who have babies out of wedlock, and the list is longer. In the interest of time, I will move on.

Our founding fathers designed a system that left many decisions concerning public welfare at the State, and, indeed, at the local level. It is time we returned that authority and responsibility back where it belongs.

I believe that the NGA policy that we recommend today does just that, by building on and improving the framework for welfare reform that was laid out in the H.R. 4 conference agreement.

That conference agreement, as you recall, contained numerous changes and significant changes due specifically to the influence of this committee. So, that became a starting point when we looked at the Personal Responsibility and Work Opportunity Act.

We also recognize that, in order to have successful reform, we had to address the concerns that were raised by the President in his veto of that H.R. 4 conference report. So we tried to establish what would be a win-win-win situation for the goals set out by the Congress, the goals of the President, and the goals of the Nation's Governors.

For example, the following. It defines welfare as a transitional program leading to self-sufficiency and provides time limited cash assistance to beneficiaries; recognizes that work must be a require-

ment; that the best work is a private-sector job; that community service can be appropriate, while effective sanctions for those who refuse to work are always appropriate; guaranteed and predictable funding with a contingency reserve to supplement State cash assistance programs during periods of economic downturn; flexibility for States to expand and strengthen programs; to encourage family stability and to deal with one of the Nation's most urgent problems, the reduction of teen pregnancy and out of wedlock births; support for tougher child support enforcement efforts, especially for the interstate cases; and improve coordination and conformity between a State's cash assistance program and the food stamp program.

For example, under current law, if a State sanctions AFDC recipients for failing to meet work requirements, their food stamp allotment rises, nullifying the effectiveness of the sanctions. The NGA policy fixes that problem. We are delighted that you built a base on which we could build, and there are a wide range of provisions which I think we have common support for. So, we applaud the work the committee has done.

Now, the compromise that Governor Carper will explain in moments has several key changes, but it is based on the vetoed bill, where we take that bill and address those concerns I mentioned.

We believe that the changes based on the following principles are such that the Governors, the Congress, and the White House can all agree. First, welfare reform must foster independence and promote responsibility; second, as we restructure welfare children must be protected; third, the ability of States to meet the needs of at-risk individuals during times of economic downturn must be protected; fourth, given agreement on broad goals, States must not be subject to overly-proscriptive standards. The welfare reform policy adopted by the National Governors' Association includes very specific recommendations to address these concerns.

Now Governor Carper, Mr. Chairman, with your permission, will discuss some of these recommendations, and then I will finish up. Thank you.

The CHAIRMAN. Tom?

STATEMENT OF HON. TOM CARPER, GOVERNOR OF THE STATE OF DELAWARE

Governor CARPER. Mr. Chairman, it is great to be before your committee. Thank you for inviting us, and thank you for scheduling these hearings in such a timely and prompt way. My thanks to the members of the committee for rearranging, I suspect, your schedules in order for you to be here to hear from us, and for us to hear from you.

Let me preface my remarks by saying so far I have counted seven times the use of the word "bipartisan" in the comments of Governor Thompson, Governor Miller, and Governor Engler. It's an important point.

The reason why we have come from rather polar views to a consensus where 50 State Governors can agree is because we have worked with the leadership of Tommy Thompson and Bob Miller across party lines. I would just sincerely urge you to do the same thing here in the Senate and in the House.

A couple of general comments, and then some specifics. The views of the President, I think, are well-known and well-stated on welfare reform; your views are clearly stated in the bill that you passed by a very wide margin in the United States Senate.

The President has said, and you have said, that welfare reform should reward work, it should encourage personal responsibility, it should foster self-sufficiency.

There really ought to be a litmus test, I think, for welfare reform. It should prepare people for work, it should help them find a job, it should enable them to keep working so they and their families are better off. I believe—we believe—that the proposal that we submit to you meets that litmus test.

As Governor Engler has said, we do time limit, as your legislation did, benefits. We also provide block grants, but in block granting cash AFDC we also provide, as you did, a contingency fund in the event of an emergency. Our proposal underlines the importance of child care in meeting the needs of children.

We also provide, as Governor Engler has said, for flexibility for the States, for the States to be able to be used as laboratories to experiment, to find out what works in some cases, what does not.

We reward in our proposal States that do an especially good job of moving people off of welfare onto work. In addition, our proposal rewards those States that do a particularly good job in reducing out of wedlock births. We reject in our proposal mandates from the political right, and from the political left.

Finally, we urge you to pass, as you did earlier, the child support enforcement legislation that we all need, as people move across State lines.

A few specifics, and then I will close. With respect to child care, CBO said that the conference report was $4 billion short on child care. We ask that you restore that $4 billion to your funding over the next six or seven years. We cannot emphasize more strongly the need for adequate child care funding.

In my view as Governor of Delaware, the two greatest impediments that keep people from going to work are, one, who is going to take care of my kids and how will I pay for it; and two, how can I do without health care for my family when I go to work for an employer who does not provide health care as a condition of employment. We need the money for child care.

The second point I would add, if you make the decision, as I believe you will, to block grant cash AFDC, cash assistance, we believe that it is important that you have a contingency fund. We have recommended a doubling of the size of that contingency fund to $2 billion. We have added a second trigger, so you would have two triggers. One, the unemployment trigger that is in your bill, and two, a trigger that relates to increases in food stamp case load.

A couple of other questions I would lay before you today. One of those is, really, what constitutes work? In the conference report, 35 hours a week was deemed to constitute work.

We would set as a floor—not as a ceiling, but as a floor—that 25 hours per week would constitute work; States could require more if they wished. For families that have children under the age of six, we would suggest that 20 hours a week could constitute work for participation rate requirements.

In Delaware, we are not going to wait for a year, or two, or three to try to get people to work under our welfare plan, we try to get them to work right away. I believe that some of the best training can be gained while people are on the job, and our full expectation is that, if we move people into the work force early, they will also be, in some cases, continuing their high school education, getting a high school diploma, in some cases going on to a community college. But the idea is for them to work and to gain the educational skills that they need at the same time.

I would suggest to you in terms of whether or not we count—and this is sort of a tricky one, but just stick with me if you will. In Delaware, if we had 100 people who were on welfare, and 20 of them in the first year moved to work, that would not, under the conference report, count as part of the participation rate.

We could not say that that was a 20 percent participation rate. It would be a zero, because when people move from welfare to work they sort of drop out of the common denominator. I would just simply say that I do not think you want to do that; it actually discourages what we ought to be encouraging.

The last two points. One, on performance bonuses. I mentioned this before. In your legislation, the conference report that the President vetoed, you provide sanctions for States that do not do a good job of meeting work rates or participation rates and you provide sanctions for States that do not do a good job in reducing out of wedlock births.

That is all well and good, but we would suggest that you also reward States that do a better than average job of moving people to work and that do a better than average job in reducing out of wedlock births.

The last thing I would say is, not everybody who is on welfare will go to work, can go to work. There is a percentage of that population that will never work, for physical reasons, mental, psychological, whatever. You acknowledge that in your bill, and I think you provided for a 20 percent hardship exclusion. I think you are on the money, and we would suggest that you continue that.

Let me bounce the ball back to Governor Engler. Thank you.

Governor ENGLER. Mr. Chairman, Governor Carper and I have both referred to flexibility. In the reform proposals we have put in front of you a number of very specific proposals would lessen the proscriptive requirements, increase State flexibility, and, I think, strengthen and increase accountability.

The States would have the option to restrict benefits to additional children born or conceived while a family is on welfare, so, in effect, you could have a family cap.

We set an administrative cap on child care funds at 5 percent; an effort to assure more funds get to needy cases. It also raises the hardship exemption to 20 percent.

It adds a State plan requirement. States set forth objective criteria for the delivery of benefits and for fair and equitable treatment with an opportunity for a recipient who has been adversely affected to be heard in a State administrative or appeal process.

This is very consistent with what we are doing in Medicaid, the effort to move this litigation out of the courts into administrative process so it can be promptly resolved, but, in all cases, to stay out

of the Federal courts unless the Secretary wishes to bring an action on behalf of an individual or a class, but end the rush to the courthouses across America.

In child welfare, again, we think that the proposal strengthens concerns that have been raised about the protection of children. We would, first, maintain—and this is a change from the conference report that has been agreed to—an open-ended entitlement for foster care and adoption assistance, maintenance administration and training as under current law.

Second, would be the creation of a child protection block grant that does consolidate the remaining child welfare, the abuse and prevention treatments, family programs in one block, and then finally giving the States the option of taking all their foster care and independent living funding as a capped block grant, and then that would give them the chance to have some flexibility.

But they would have to maintain their effort at 100 percent based on prior years so, in effect, you could not put it into a block and divert the funds. You could put it into the block, gain the flexibility, but have to have a floor then.

In this case, because of the concerns that have been raised publicly, we said, let us leave it at 100 percent, because we think that is an area of prevention that frankly pays big dividends, so we do not think that States would be, in effect, wanting to cut back, nor should, for policy reasons, desire to cut back. So, prompt action is important. That is the only conclusion.

We think that reform affects people in Michigan, and is probably true around the country. Twenty percent of our case workers' time is helping clients achieve independence, 80 percent is pushing paper.

I brought a chart today, and I realize with the size of the room the chart is a little small, but this talks about a reform proposal that we are trying right now. We call it Project Zero. We are trying in six districts in the State, four full counties—two areas in the populous Wayne County—to actually do an effort where we put every single recipient to work. We want to see how far we can get, how much success we can have.

We did a survey, and they reinforce what Governor Carper just said, on the key points that are trouble. Child care and transportation; what does somebody do? We think this welfare reform enables more dollars for child care and transportation.

Health care. Again, it allows us, when you take into consideration the Medicaid changes, to address the health care issue for those who leave welfare for work. This happens to be an area in which, for 2 years, we have had a waiver request pending.

Finally, mutual responsibility. In our program we are not looking at 5 years and out, we will have a 60-day time limit. If somebody does not go to work in 60 days, the job is there, they will go off the rolls. We think that is an effective sanction, and long, long overdue.

Finally, the administrative burdens, which I just mentioned and I already testified about, the linkage on the sanctions which is so, so important.

So we are encouraged to be here today. That is a very, very quick overview from Governor Carper and I of welfare reform, and we look forward to the questions.

The CHAIRMAN. Well, thank you very much for your brevity, because we are eager to get to the questions.

We will turn to Governor Chiles, Governor Engler, and Governor Romer on Medicaid reform. I do not know who is to be first.

Governor Chiles?

STATEMENT OF HON. LAWTON CHILES, GOVERNOR OF THE STATE OF FLORIDA

Governor CHILES. Thank you, Mr. Chairman and members of the committee. Thank you for allowing us to be here today. We come today with our best attempt at trying to come with a bipartisan plan that resolves our differences. It is not based on any proposal in the Congress; it does not assume a Medigrant I, Medigrant II, per capita bills that had been introduced. We do not seek to repeal Title 19 or incorporate the legislative language of other proposals.

So, literally, it stands on its own as an outline of what the Governors think the Medicaid program should look like. At best, it is an outline and we know that it can be improved.

Medicaid is much more than an ideological concept for Governors, it is a program that totally monopolizes our attention, our planning, our rendering of services, and perhaps most importantly, our State budgets. I would like to focus today on some of the critical guarantees that this proposal provides.

First, it provides a guarantee of eligibility to the individual. In earlier proposals, set-asides to groups were used to ensure that individuals would receive coverage. The Governors' proposal changes that, while we maintained the strength of the current law for eligibility. If you are eligible for Medicaid today, with a few exceptions, you would be eligible under our proposal.

States would be required to serve all pregnant women below 133 percent of poverty; all children age six under 133 percent of poverty; and all children 6-12, 100 percent of poverty; all of the AFDC recipients through current AFDC or a new cash assistance program; all people with disabilities, as defined by the States and approved by the Secretary of HHS; all elderly SSI recipients, and all poor elderly recipients on Medicaid for the cost of their premiums, co-pays and deductibles.

In addition, the eligibility categories, which are optional today, would remain optional under our proposal. The fundamental principle that our most vulnerable population should be individually guaranteed entry into the program is really what helped bring our group together. This is a structure that we think is critical to any Medicaid reform proposal.

Today when a pregnant woman at 125 percent of poverty walks into a Medicaid office, she is guaranteed entry into the program. Earlier proposals would have left her eligibility up to the State. The Governors' proposal rejects that approach. That pregnant woman today—indeed, any pregnant woman up to 133 percent of poverty—is automatically eligible for Medicaid. We think it is important to maintain a meaningful safety net of benefits.

For all guaranteed groups under our proposal, the current mandatory benefit package, with few exceptions, would continue to be mandatory. The States would have some discretion beyond that mandatory package to tailor specific benefits to populations in need.

What we really hope is that all of us will be able to expand the safety net, by having this flexibility, to the working poor who, by and large, today do not have health coverage.

The flexibility that we are asking for is nothing new to members of this committee; it is what drove many of you to support the block grant proposal to start with. But in our agreement the Governors wanted to make sure that that flexibility that we got was real. None of us want the flexibility to slash the program, but, under some of the earlier numbers, that is exactly what we would have had to use the flexibility for.

Because the Federal Government's participation was absolutely limited through an aggregate cap on Federal spending, States would have been left with no Federal partner. That is where, as Governors, again, we have taken a strong bipartisan stand. Our proposal does not have an aggregate cap. Our entire compromise is constructed on two fundamental principles: flexibility to the States—massive flexibility—and a true federal/State partnership for financing.

These two principles, we think, must be linked. You cannot have true flexibility without a Federal partner that will bail you out in the tough times, and you cannot achieve the savings that you need without allowing the States the flexibility to run this program more efficiently.

I want to emphasize this major point on which we all agree. The umbrella fund for our proposal is uncapped, it is not subject to appropriation, it is an entitlement. When more people become eligible for the program than expected the umbrella responds automatically, helping to provide critical health services to the individual.

So if we experience a recession or a natural disaster and have a tremendous increase of the number of people that we would have eligible on our rolls, the Federal Government will be there as our partner, sharing the burden with the State.

My particular State, in Hurricane Andrew, we had an immediate increase of 12,000 people on the Medicaid rolls overnight, literally, in Dade County. Without a strong Federal partner during these difficult times, we would have been on our own. Those families that needed care would have been in very serious trouble. Some see this as a protection for State budgets; literally it is a protection for the individuals in the program.

That structure is the core of our agreement, and that is why this group is before you today. It is a true compromise. Giving a State flexibility without the adequate resources to cover the needy would just force us to cut our rolls, slash service, and undermine the overall health of the population. I know we all share a commitment to maintain this critical safety net.

As Governors, we are ready to begin work on a true bipartisan approach to reform the Medicaid program. We know that it has to have an awful lot of work from you. We stand ready to try to help in any way we can in that program.

The CHAIRMAN. Thank you, Governor Chiles.
Governor Romer?

STATEMENT OF HON. ROY ROMER, GOVERNOR OF THE STATE OF COLORADO

Governor ROMER. Mr. Chairman, I would like to use the blackboard, if I may, to diagram this program. I think in the question and answer period it will help us be more precise. Is that permissible?

The CHAIRMAN. Please proceed.

Governor ROMER. This is based on a base which would be the year 1995, 1994, 1993, or a combination. That base would increase over a 7-year period. Now, that increase would be based upon a factor of inflation and growth. We have not come to a detailed specific formula on what that factor would be, because it must be scored and tied within your budget allocation.

But, hypothetically, let us assume that growth is 3.2 percent, and let us assume that CPI is 3.8 percent. That factor, hypothetically, could be a seven, or it could have an addition above and below CPI, if you wanted to add it. This would be designed to meet the budgetary requirements of 59–85, or whatever the Senate and the House would decide.

Then on top of that would be the umbrella, which would be what was described by Governor Chiles. Here is the way it would work. At the beginning of the year there would be an estimate for each State of the number of persons to be covered.

Then at the end of the year, if that number actually exceeded the estimate, then you could penetrate this umbrella and receive additional compensation. If the number in a State was less than the estimate, you keep the money.

Now, each year this estimate of numbers is remade, so that the estimate of the number of people to be covered should be fairly accurate. What will throw us off, is if we have a major recession or a hurricane in one State or the other. So, this additional fund should be one that should be recognized to take care of circumstances that are beyond our ability to predict.

Now, what I want to describe, is that this is a true combination of a per capita cap and a block grant. It is based on the per capita cap side by having the formula, you get paid for the number of persons that you serve and you increase that with a factor or inflator each year.

On the block grant side, once you get your money, then you have flexibility to spend it other than on the mandatory eligibility and the mandatory benefit package. Beyond that, you can spend those funds, as a State, as you see fit.

For example, if you are more efficient and you can keep your growth below 7 percent, you can take those savings and apply it to other groups, or, if you want to reduce your optional eligibles or optional benefit package, you have the permission to do that and apply it to other groups. That is the distinction from current law. In current law you only get it if you spend it for the group you labeled. Here, you get the money and you have the flexibility on your optional side to use it for other groups.

Now, let me just describe DSH as I go here. DSH is a part of the base. DSH would increase each year by the same factor of inflation, but there would be a cap that DSH could not exceed 12 percent of the total amount spent. Therefore, those that are above 12 percent now would not receive any additional DSH payments, those that are below 12 percent would rise to that. So, eventually, there will be a coming together on a uniform basis of what each State would receive under DSH.

So DSH is a part of the base. There is one distinction I want to make. Let us take Florida. Florida would have above its estimate a 5 percent increase in the elderly population. It would be paid on a per person basis for that, based upon what it is now spending for the elderly, so DSH would not be a part of the compensation for that calculation. Some of my colleagues may want to describe that in a different way, but that is one of the pieces we are still working out.

In summary, this is the basis of this agreement. Now, there are aspects of this that is work-in-progress. There are certain pieces of it, the terms of the guarantee package, that we are still attempting to clarify, such as the definition of disability, such as amount, duration, and scope, and we are, as Governors, continuing to work through some of that material. This is a very brief description of the guts of this compromise.

I think there is one other thing that I might add. That is, do you include the amount that may be required in this umbrella as a part of the amount allocated in the budget package? You could argue it either way. I would like to argue it and say, this additional cost is only going to be there if you have a major recession.

Since the whole of the budget package is, again, predicated on certain economic projections, I would suggest that if it needs funds, it should be above and beyond what is budgeted for this because it would be due to a major change in the economic projections which affect the whole of the package, not just Medicaid. So, with that explanation——

Governor THOMPSON. Roy, before you leave, why do you not just put that sliver in there, Special Grants, that is in there between the inflator and the umbrella.

Governor ROMER. There is a special area here for special grants, such as the alien population.

Governor THOMPSON. Illegal aliens and Native Americans.

Governor ROMER. Native Americans. And it is anticipated that that may be one which would be funded totally by the Federal side, not by the States.

Governor ENGLER. Mr. Chairman, the other point that Governor Romer may wish to clarify is that before you are eligible to go into the umbrella you must expend any savings that you may have carried forward first, so you do not go automatically to the umbrella.

In other words, it does take up extra money that you may have had in the drawer that you were saving for the rainy day. So that is another thing that we think lessens the cost of the umbrella.

The CHAIRMAN. Thank you, Governor Romer. Does that complete your statement?

Governor ROMER. Yes, it does.

The CHAIRMAN. Governor Engler.

Governor MILLER. Can I clarify one component from earlier, Senator? That is for all elements. The penetration of the umbrella is not included in the category he talked about if it is for underestimated growth. In other words, if there is a mathematical calculation error, you can go in there to receive for people that worked appropriately forecast. But, if you penetrate it for other reasons, natural disaster or something of that nature, then what he says is accurate.

Governor ENGLER. Thank you, Mr. Chairman.

Mr. Chairman, States like Michigan are ready to transform Medicaid from a very costly budget buster into a more effective, more accessible health insurance program that encourages independence.

Let me emphasize, first, how vital it is that Medicaid be reformed. Medicaid was 8 percent of Michigan's general fund budget as recently as 1980. Today, it is at 20 percent—one out of every five general fund dollars we spend—and is skyrocketing toward 30 percent by the end of the decade.

What really ought to bother the committee, perhaps, is that Michigan has done a pretty good job, when compared to other States, in controlling Medicaid costs. For example, we have been very aggressive in implementing managed care. Since we really began in the 1990's, we have enrolled 95 percent of our AFDC families in some form of managed care. That has helped us. We have been able to reduce the rate of increase in base Medicaid costs to 6.2 percent in fiscal 1995. So that was, we felt, a good step forward.

With the reform that is included in the bipartisan Governors' proposal that we bring to you today, we think we can make further improvements in holding down base increases. Plus, the important dividend for people who need help, is that we believe we can now expand, with flexibility, Medicaid coverage to reach an additional 30,000 children who are not covered today.

With reform, we also will expand in-home care for elderly by $50 million. That recommendation is actually in my fiscal 1997 budget. We would expand coverage by adding hospital care for some 32,000 indigent adults. So that is what reform means. I think in State after State it gives us the flexibility to meet some of the most urgent needs to remove some of the barriers that stop people from going to work.

So that is very good news for at-risk families who may, but for innovations on the part of the State, end up feeling that welfare is their only option. It certainly is good news for the parents, and we have been able to have 70,000 families in the last two and a half years move off welfare. We want them to stay off for good, so we have to deal with them and we have to deal with their children. That is the big picture.

Some specifics. The Governors' policy on Medicaid proposes changes to the current law, with its entitlements to individuals, to a new law that provides a Federal entitlement of funding to the States who then, as Governor Miller testified, have specific guarantees of coverage for vulnerable populations, and those are very specific. Those are pregnant women, those are poor families, those are persons with disabilities, and elderly.

Now, what does this mean? I think it says to the States, clearly, that we must set the policies and the rules, but that we also have

to be accountable to the people of our States and the people of the Nation in administering the program by those rules and policies.

This is specifically set up to address a very specific criticism that was included in the earlier veto of the reform measure, that there was not protection for specific populations. We believe that we have met that test.

It means every person in a State should be able to obtain benefits defined by that State, and it means also that every person, every provider, does have a right of action to assure that the State plan is being administered fairly.

One change, as I mentioned in my welfare testimony, to reiterate, there should be no right to go immediately to the Federal court. Indeed, our proposal is designed to prevent States from having to defend against suits on eligibility and benefits in Federal court.

Now, it does not mean that someone's right is being taken away, it just simply means that the right of action begins with a State administrative process and continues in the State courts.

So we recognize the imperative to protect due process rights, but we do not think that every grievance needs to become a lawsuit, as is so often the case today, especially when it is government-funded lawyers, often on the other side.

The States will end up negotiating this process with the Secretary, and the Secretary, as part of the State plan, will approve our appellate process or our hearings process.

The NGA policy also gives the states the opportunity to choose from the widest variety of available health care delivery systems, and I believe will spur further development of new systems and new models. We could all talk about specific populations where we hoped to serve someone today who cannot currently be served.

Governor Levitt will tell a story of a comparative study they did using the Medicaid guaranteed contract compared to private insurers' benefits in the State of Utah, and they found in the vast majority of cases that the benefit under Medicaid was outstripping and outpacing what was available in the private sector. He believes reconciling those two and then freeing up extra dollars means more children get covered.

I believe, also, that it gives us flexibilities on programs for elderly. We know that nursing homes are an expensive option today. Today, to change that, States have to come to Washington, DC and file waivers. Every time they want to change a State plan, which is thousands of pages in some cases, they have to file more amendments and waiver requests.

Now we will be able to move on that, we will be able to target services for the elderly in their home. I think the result is many of them being able to stay out of nursing homes much, much longer.

The need for State flexibility is also illustrated, clearly, by the amount of waivers being requested by States. All States have waivers for home and community-based services. Roughly 90 percent of the States have some type of waiver for some type of managed care, but only about a quarter of the States have Section 1115 waivers.

So you have got States really trapped in a failed system, struggling to get out. The Federal Government is sort of in charge of waivers and sort of doles them out like favors at times. So that will change. The current process is very arbitrary.

We know of examples where one Midwestern State got a waiver, and then another State came in, filed exactly the same waiver, and they were turned down by the same bureaucracy; maybe somebody had had a bad day. And, as I mentioned earlier, we had a 2-year wait, and we are still waiting.

The Boren Amendment is repealed. It is a terribly costly item. It was originally worked on and supported by the Governors, but when it got into the Federal courts, instead of being a tool, it became a lever; instead of being a ceiling it became a floor. Bottom line: the State flexibility will allow us to dramatically improve the status quo. We just urge prompt action.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Governor Engler.

For the benefit of the members who were not here at the beginning, we are going to limit each round to five minutes. I also would mention that Governor Carper has to leave early, so that those of you who want to ask questions on welfare reform should emphasize those in the beginning.

At this time I would like to recognize the Lieutenant Governor of Michigan, Connie Binsfeld. It is a pleasure to have her here.

Lieutenant Governor BINSFELD. Thank you, Mr. Chairman.

The CHAIRMAN. I would like to ask Governor Carper and Governor Engler a question regarding the vetoed welfare reform bill which was estimated to save $64 billion over 7 years. I understand that the Governors expected that the changes they made would decrease the savings in the conference report by $6-8 billion. Now, CBO's preliminary estimate is that the savings loss is $15-20 billion.

So my question is, would NGA modify their proposal in light of CBO's preliminary estimate? Has any thought been given to that?

Governor CARPER. Speaking for myself, I do not believe so. I do not know if Governor Engler or I mentioned this, but we have not said, as Governors, whether we supported or opposed the provisions in H.R. 4, the conference report on legal aliens.

The CHAIRMAN. On what?

Governor CARPER. We are silent with respect to aliens. There are some costs, some savings that certainly will accrue to whatever language you ultimately adopt there. There are Governors at this table, particularly Governor Chiles, who has a strong interest in what you ultimately adopt with respect to treatment of aliens.

We will work with him, and Texas, and California, and other States that have a strong interest, and I know they will want to work with you. So that is a question mark, and it explains some of the difference.

If my memory serves me correctly, my recollection of the Senate-passed bill was scored at something like maybe $50-51 billion in savings, I believe. We have added another $4 billion for child care. You can back that out of there. Another billion dollars for the contingency fund. That is about $5 billion. So, I would certainly presume we would be somewhat less in savings than the Senate bill.

Having said that, again, I am going to go back to what we believe is important for people to be able to move from welfare to work. One, we have got to help them with child care. Two, we have got to help people with health care. Three, some of us have mentioned transportation.

In order for people to move from welfare to work they need a job, they need a way to get to the job, they need some help with child care, and they need some help with health care.

I think, in terms of policy, the kinds of policies that we are recommending actually help people to make that transition. In terms of the dollars, we need to work with you on that. Clearly, you are in the driver's seat on the budget with the President on trying to meet your deficit reduction package. The policy, for us, is important.

The CHAIRMAN. Governor Engler?

Governor ENGLER. I think that it would be very difficult. I am not familiar, obviously, with the details of their preliminary numbers. Governor Carper makes a very good point on the alien question. I do not know if that is included, particularly when it is scored. I will tell you, the Governors were not unanimous on that point, given the different impacts to different States.

I privately have an assumption that what the Congress did on that issue was done fairly comfortably before in terms of the margins in both House and Senate, and that it likely would not change very, very much. So, whatever savings were there probably are still there.

I am not sure if CBO treated the EITC at 10 versus five or 15, because we know that is not before us. But it is obviously related, and so Governor Carper and I did the honorable thing there.

We said, one side has got 15, one has got five, we will just make it 10 and not dwell on it because you are ultimately going to make that decision anyway. So we have, as an organization, supported EITC.

In fact, that is another area where we would like to see some changes so we could advance whatever EITC program remains on a monthly basis, because so many employers find that onerous. We think the State, which is sending checks to some of those people, could do that much easier, making the program more effective.

I think that we tried to keep in mind, first and foremost, the policy. We think the policy will save, literally, billions over a period of time. When I look at the size of the budget, even when I look at the remaining gap on the deficit, I mean, we are down into $6–8 billion versus $15–20 billion.

Maybe it is $7 billion on the low side, maybe it is $14 billion on the high side for a budget of our size, and this is over 7 years, so we are down to $1–2 billion a year here. We just cannot get it so close; maybe CBO can. But we think we are in the ball park.

We think the policy is so good, the individual entitlements and the other State flexibilities, that I think, when you look at this program in a few years, we are all going to save money because you are going to see people going to work.

Governor THOMPSON. Mr. Chairman, if I could just add one thing, very quickly. That is, you asked a simple question as to whether or not the NGA would be willing to cooperate. Yes. On a

bipartisan basis on these policies, we want to make sure that the Democrat and Republican Governors are able to work with you in a cooperative basis. In order to get the thing through, we will certainly cooperate in any way possible.

The CHAIRMAN. Well, I appreciate that very much, Governor Thompson. My time is up, and I am going to try to strictly enforce it, so we will get back to this.

Senator BREAUX. Well, thank you very much, Mr. Chairman, and I will thank the panel as well. I mean, I think that the very serious challenges that we face on health care reform and welfare reform are not Federal problems by themselves, they are not just State problems by themselves, they are not just local government problems by themselves, they really are truly national problems, they are American problems, and we all have to be involved in the solution to the problems. We cannot just do it from one perspective and not involve everybody else.

But I think that any ultimate solution has to be a sharing, a sharing of the benefits to the changes and a sharing of the cost that the changes also incur. We are going to both have to deal with the burdens and the benefits of whatever programs we come up with.

So let me just say up front that I think that what you all have done is a very positive contribution; it has moved the process forward immensely. The fact that we are having hearings today, Mr. Chairman, on a specific recommendation on both Medicaid and welfare, I think, is very significant. I daresay it would not have occurred had it not been for the good work in bipartisan fashion that the Governors have done.

But let me ask some questions about money, which it always gets down to. I am concerned about the proposal that I see on welfare, in particular. We have a $2 billion new contingency fund and we have added $4 billion to child care. But, as I read the suggestion from the Governors, there is no requirement that you all match the $4 billion. In other words, more than 75 percent.

In other words, on the $4 billion child care you could cut your spending by 25 percent and have the Federal Government make up that difference, and on the contingency fund of $2 billion—which I think is a good idea—again, there is zero maintenance of effort for you to get the $2 billion.

So it seems to me that what you are saying is, we are talking about more money in two significant areas, but with a far less, if any, contribution coming from the State. That is a sharing of the benefits, but not of the cost, any solution has to be both.

Can you comment on that?

Governor CHILES. I would like to comment on that just a minute.

Governor THOMPSON. Well, you go first. I would like to comment, John.

Senator BREAUX. Lawton used to comment on that when he was Chairman of the Budget Committee.

Governor CHILES. Well, sure, John. I understand what you are saying about the sharing, but let me tell you where we find ourselves. All of us are trying to move to take people off of welfare. Florida has two major counties in which we have a demonstration

project. We are in the end of the second year in that. We are achieving great success.

But the two essential things that you have to give that mom to get her off of welfare are child care and health care. It is not a negative cost program. It costs money and it looks like, now, it will cost us. In 3 years and 2 months, we will have to invest money into that program, thereafter, we will save for a long time.

Now, I can just tell you how it affects my State. I am asking my legislature for an additional $60 million for child care. If I get that and I get my share out of the increase of the $4 billion, it looks like we would be able to take welfare reform to the entire State. There is no way we can do that without incurring these additional costs; I am incurring that already. That $60 million that I am asking for, I have to have from my legislature to go with what I will get out of the $4 billion.

Senator BREAUX. But here is the point, Lawton. I agree, and everybody agrees, we need more money for child care. But what I am saying is that, under the proposal I am looking at from the Governors' Association, is that, say a State has spent $10 million on child care last year. They could spend $9 million next year under your proposal and make up the difference from the $4 billion coming from the Federal Government.

In other words, the State would benefit from the reduction in spending on fewer people on welfare in your State, but the Federal Government would not. You can reduce your spending by 25 percent and still get the same contribution from the Federal Government.

In other words, we do not get to reduce our spending by 25 percent like you did. On the $2 billion contingency fund, I see no requirement that there be any percentage of match. In other words, it could be 100 percent Federal Government, zero from the State. That is a good deal for somebody.

Governor THOMPSON. Senator, if it was true, that would be a good deal. The truth of the matter is, like my own State, we have reduced welfare case load by over 33 percent. Every time I move people off of welfare, which should be laudatory, by everything I get penalized for lack of Federal dollars.

The truth of the matter is, I am spending more on State dollars, much more than the amount of money I get, because in order to go from a dependent system to independent you have to spend more money on travel, you have to spend more money on job training, you have to spend more money on health care, and all of these things usually are 100 percent at the State level. Anyway, they were when I started this program, so I am spending a lot more.

But when you say 100 percent participation instead of 75 percent, you penalize the good States that are trying to move the system. That is the difficulty. We are spending—Lawton, and a lot of us up here—a lot more money trying to change the system, and that is where the 75 percent comes in. Give us some flexibility, because we are spending more money to change the system, and that is 100 percent State dollars.

Senator BREAUX. I heard that. My only final point would be that, if a State could reduce their spending by 25 percent because of good practices, should not the Federal contribution, because of

those good practices, also be able to come down 25 percent? It does not do that in the proposal, as I see it.

Governor ENGLER. The advocates have argued that the effect of reform has been to weaken safeguards that are in place. We think it is exactly opposite of that. To answer specifically, on the contingency fund, I believe if we want to draw that down we do have to match that, the way we take other dollars. That is our understanding of that, that we would have to match on the contingency fund.

Senator BREAUX. Is that the intent of the plan? Because I do not see it in there.

Governor ENGLER. Yes. On the child care fund, you are correct, there is not a match on that additional $4 billion. But, again, that was a response to criticism from some organizations who have said that the bill was weak on child care.

I will give you an example, if we do not get reform. I am trying, out of some of my other savings now—and this is current year—to up my child care investment. But, if I do not get the flexibility, I will not be able to increase it, and that is 100 percent on the State side. So, that can fall either way.

Right now, the difficulty that some States have, what the child care advocates were criticizing us for, was that some States, under the current Medicaid system, are so locked in with the match system that is structured, that it is consuming, as I said in my case, up to 20 percent of the general fund budget, and is now rising. It has been that way all over the country.

So they said, well, if you put in extra money for child care but they have to match it, they will not have the match and they will not spend it, and the children do not get help. So, that is why there is no match there. But, again, that is a decision that we have agreed on. We recommend it to you without the match.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Chafee?

Senator CHAFEE. Thank you very much, Mr. Chairman. I would like to join in the commendation that we have all given the Governors, Republicans and Democrats, for coming up with these two proposals that clearly will advance us along.

I know Governor Levitt is not here, but I want to pay tribute to him also because we have all seen him over the past year that this has been worked on.

First, it seems to me, as I read your proposal—and this was touched on before—you, in effect, did not deal with the immigrant proposal at all. Am I correct in that?

Governor THOMPSON. Correct.

Senator CHAFEE. I do want to point out that that is a very, very substantial portion of the savings. It is something close to 40 percent of the savings in the legislation that we have advanced in the Senate and, indeed, in the conference report, likewise.

So if I understood the answer that you gave to that, you would be prepared to work with us. Governor Chiles obviously has deep concerns over this, that perhaps somebody from Utah might not. However, that is a big ticket item that we are going to have to deal with.

Second, I would like to get back to see if I understand the situation that Senator Breaux was touching on, because I had the same question. Under the Senate bill—I am talking the Senate bill, now—we required 100 percent maintenance of effort—and maintenance of effort being based on what you have done in the past years—in order to access the additional child care and the contingency funds.

If I understand what you are saying, you do not require a maintenance of effort, in other words, you could be at 75 percent. Is that right, or am I wrong? You could stay at your 75 percent and still get the contingency and, as far as the contingency dollars, you would not have to match those either. Am I wrong on that?

Governor CARPER. I believe that is in error. There is a required match on cash AFDC. My understanding is that would continue.

Senator BREAUX. Would the Senator yield? John, I think that the difference was, you have to match it but there is no requirement for a maintenance of effort to spend any percent of what you spent the year before. You have to match to get it, the $2 billion, but you would not have to have a percentage of maintenance on what you spent last year.

Governor THOMPSON. You would have to have the 75 percent, our policy reads specifically. Yes.

Senator CHAFEE. You would have to have the 75 percent; you would have to be up to that of your prior years' effort. But to get $1 million from the contingency fund you would not have to match that on whatever your matching formula is. Let us say you are 50/50. Is that right?

Governor THOMPSON. You would.

Senator CHAFEE. You would.

Governor THOMPSON. That rate applies. Yes, it does.

Senator CHAFEE. When everybody shakes their head yes, I am not sure if they are agreeing with what I said.

Governor THOMPSON. We have to maintain at 75 percent, but in order to get the contingency fund we have to also match it.

Senator CHAFEE. All right.

Governor THOMPSON. You have got to match.

Senator CHAFEE. All right. I understand.

Governor ENGLER. To get to the contingency fund, Senator, that is not just, as Governor Chiles would say, money on a stump. You have got to have some pretty serious things going on in order to be eligible for the fund. You have got to have some rather dramatic things happening in the economy or a 10 percent increase in food stamp case load, which would be pretty dramatic. I mean, we would be noticing that in a lot of other areas, too.

Senator CHAFEE. I am going to stick, Mr. Chairman, to the welfare now, knowing Governor Carper has to go, and then I will deal with Medicaid when we go around next time.

You keep the foster care and the adoption assistance as an open-end entitlement.

Governor CARPER. Yes, sir.

Senator CHAFEE. The other child welfare programs—we know them as those that fall under the Labor Committee's jurisdiction—would be in a single Child Protection block grant. In addition, States would have the option to take foster care and adoption as-

sistance as a capped entitlement block grant. You could take that as block grant, and you can reverse this decision every year.

Now, I have great respect for Governors, and they are very, very smart. When I see an option to change things every year, I think that might be more oriented toward the welfare of the States than toward the welfare of the Federal Government. I do not mean to be facetious, but Governors are looking after their treasuries, which is what they are paid for. That is what they are hired for.

Why do you have this switching business in there?

Governor CARPER. There are some States that might elect to move off of the entitlement approach for child protection/child welfare to use a block grant and find out that that was not working, it was not working well, they were unable to meet the needs of youngsters who might be involved in adoption, or foster care, or to preserve families. We want to make sure that the States in that instance would have the opportunity to go back to the entitlement. It was simply for that reason, and no other.

Senator CHAFEE. All right.

Governor ENGLER. To concede that point, that is an area where I think we are flexible in terms of being able to work. I concede the point, changing every year would not be good policy. But if you wanted to have a limit on, you know, if you go in once you get one exit out and then you have to stay, or something, I think we can work with that.

Senator CHAFEE. Well, my time is up. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator Chafee and I tend to have exactly the same concerns. Mine, too, are on child welfare, foster care, and the optional block grant program. I, too, worry about the changing back and forth, Senator Chafee. This is a six-page document. Of course, I am showing you the document on Medicaid, not welfare. But, however we write up this thing, the devil is always in the details.

How can we be sure—I ask this to Governor Carper—that abused, neglected, or poor children are going to get care? Governor Engler represents a State that used to, in fact, exceed the State of West Virginia in unemployment. Then we exceeded them for awhile, and now they are doing better, and we are doing better, too.

But when unemployment rises again, and State money runs out, problems mount for children, unemployment grows, families become more dysfunctional, children are more at risk, families are more at risk. So, the whole isssue is making sure that a child does get this protection.

Supposing there is a great increase in case load and Governor Engler, Governor Carper, or Governor Chiles discovers that their optional grant money is pretty much used up by August. What do they do? How can we be absolutely sure in the Congress that each abused and neglected poor child is going to get cared for?

Governor CARPER. Let me just say, we did not craft this approach for a State as a block grant option on child protection/child welfare. We built it off of a consensus that was hammered out with the American Public Welfare Association.

The scenario which you paint, Senator, where a State will be running out of money in a block grant situation and unable to meet the foster care needs, the adoption service needs, the family preservations needs of a particular constituency, is the very reason why we give States the option of going back at the end of a year to the entitlement, which is simply to protect families and kids in those very situations.

I would also say, we maintain if a State—Delaware, Michigan, or any other State—wants to continue the individual entitlement under child protection, they may do that. If they decide to select the block grant option for a year or two or three, they still have to meet a 100 percent maintenance of effort requirement. They cannot go to 60, or 50, or anything else; it has to be 100 percent maintenance of effort there.

Second, the requirements under current law, State and Federal law, must continue to be met. We believe, in Delaware—and I would say there are some approaches where I think the entitlement is the far preferred option—we may be able to provide better service to kids and families with the block grant approach.

Senator ROCKEFELLER. Let me use Medicaid to make my point.

Governor CARPER. All right.

Senator ROCKEFELLER. On page two in Medicaid, you describe the benefits and you say, "The following benefits remain guaranteed for the guaranteed populations." In a sense, this also applies to foster care, Title 4, for abused children.

Then on page three in your last provision, "States have complete flexibility in defining amount, duration, and scope of services." In a sense, this makes everything under benefits totally at the State's option. It would seem to me, that is the concern that I have in terms of guaranteeing benefits for abused and neglected poor children.

Governor ENGLER. All right. Let us put the two policies together. I appreciate the benefit, really, of having both of them here today in one committee. In child welfare, first, what are we recommending? We are saying that we would maintain an open-ended entitlement for foster care and adoption assistance, the maintenance, the administration, and training, as in current law. All of the protections in current law under either option remain in place.

Second, we would create this child protection block grant which consolidates funding for the remaining child welfare, family preservation, child abuse prevention and treatment programs.

Now, these programs are not currently individual entitlements; I think we all know that. So, they are not, in one sense, open-ended today. We have to maintain all the protections and standards under current law. Then we create the option, which is Senator Chafee's question as well, of taking only the foster care and the independent living as a capped entitlement or block grant.

That would allow those funds then to be used for activities like child abuse prevention, because we know if we can prevent the child abuse in the front end, that is a better alternative than putting a child into the foster care system. Now, the Medicaid program——

Senator ROCKEFELLER. Can I interrupt at that point?

Governor ENGLER. Sure.

Senator ROCKEFELLER. Because my time is about to run out. I would think it might be just, in fact, the opposite. When you are dealing with, and you are suggesting, a block grant——

Governor ENGLER. An optional block grant.

Senator ROCKEFELLER. Optional block grant. But the temptation will be to deal with crises. I think, quite the opposite, the temptation will not be to deal with prevention, getting social workers into the dysfunctional families, and that you will use the money up on crises as opposed to prevention.

Why would I be wrong in worrying about that?

Governor ENGLER. Because I think the current foster care system, unfortunately, arises only after the crisis has happened, and then we are now taking the child out of the home. I mean, we may or may not be able to prevent the crises, but to the extent, in any case, we can prevent the crises, we can avoid foster care.

Senator ROCKEFELLER. But there is a lot of prevention that takes place after the crisis, because often a social worker can get in there, spend a couple of months with intensive support and straighten that family out. That is prevention post-crisis, but it is prevention also can prevent placement in foster care.

Governor ENGLER. The cost of the foster care center, I would argue, is so great in terms of actual dollar costs and in terms of the damage it does a child who has to spend time in foster care, that—once a child is placed in foster care the statistics are off the chart that the child will come back in at some other point.

So if we could prevent the abuse, or in some cases simply terminate parental rights earlier, we think that is good. I guess what we are saying is, give us the flexibility, because West Virginia may try it one way and Wisconsin might do it slightly different.

Give us some room in the system to sort of work on these, but we work on it knowing all current protections are in place. We did not get a chance to answer your Medicaid question, but all I would say is, that deals with the health care needs. We will get into that later.

But I believe that we have to file the plan with the Secretary, they have to approve our plan. If we try to give short shrift to any population, the plan will get vetoed.

Senator ROCKEFELLER. My time is up. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller.

Senator Gramm.

Senator GRAMM. Thank you, Mr. Chairman. Let me join everyone else here in thanking our panel, thanking the Governors, for putting together their proposal. I guess a cynic could say, well, we know what the fox in the henhouse now wants on a consensus basis, but I think it is also a very valuable exercise.

I think it does give us something to start from. I think, quite frankly, that we are stuck here in having passed two reforms that were strongly supported, at least among Republicans. They were vetoed by the President. I think the question now is, can we come back and put something together that can become law?

Let me just say, as a statement before I ask some questions, that I think a dilemma that I have is that, in looking at this proposal, I do not have any doubt about the fact that Tommy Thompson and

John Engler could take this welfare reform bill and do virtually everything I would want done with it.

I personally do not believe that we ought to be mandating what is covered. I reject the idea that we love children in Michigan more than Governor Engler does. That is not a view that is shared by the majority in Congress, however.

But my concern is with the Federal taxpayer, number one, paying the majority of the cost of welfare, and number two, with a strong national consensus that we ought to have a reform. I think, clearly, part of the debate on welfare reform is going to be a debate as to whether we have mandated changes, so in those cases where we do not have Governors who are firmly committed to dramatic changes, they occur. I think that is where the fault line in this debate is going to occur.

Let me ask a couple of questions about Medicaid. I want to ask about the insurance umbrella. First of all, all we have is a six-page sheet, so it is very difficult to know exactly what has been proposed.

But on this insurance umbrella it appears that the only way you could break into the umbrella would be with a change in the eligible population; that cost overruns for any other purpose, say your inability to control costs, pestilence, famine, the only one thing that would push you into this umbrella would be population change. Is that right?

Governor CHILES. Yes. But pestilence or famine could push you into that increase of population.

Governor THOMPSON. You have to have another person.

Senator GRAMM. I understand that.

Governor ENGLER. You have to have another person as a result of whatever it is, the pestilence, recession, or mathematical calculation error.

Governor THOMPSON. Senator, we were very concerned about miscalculations by this Federal board that is going to determine it. Florida, for instance, has a great growth population, as does Nevada, and we are afraid they may be under-counted. They should be able to do something about it.

Senator GRAMM. Let me ask a second question. Is this insurance umbrella subject to the match?

Governor THOMPSON. Yes.

Governor ENGLER. Yes.

Senator GRAMM. So that if you had a population growth, you have got to match this insurance umbrella by the same formula that you match other funds.

Governor THOMPSON. Correct.

Governor ENGLER. That is correct.

Senator GRAMM. And the basic trigger would be the number of people that you assess as being eligible.

Governor MILLER. That would be, not we assessed, it would be in conformity with the basic outlines for eligibility now, yes. We would give a number.

Senator GRAMM. But under this new bill you are going to have a lot more flexibility and eligibility.

Governor MILLER. No. Only in creating potential new categories with savings and others, but it would have to follow the basic out-

lines under the mandatory and optional populations that exist under Federal law.

Governor THOMPSON. Senator, there would be a verification. It is the old, trust but verify, from the National Board.

Senator GRAMM. In terms of flexibility that a State has in terms of eligibility in the program, is there a protection here for a State that might raise the eligibility and, therefore, trigger the umbrella?

Governor THOMPSON. You cannot do that.

Governor MILLER. You cannot do that by a new category, it has to be by existing categories.

Senator GRAMM. All right. Well, it seems to me that I think one of the arguments that you can make—and I think it is a fairly strong argument—is that in terms of this flexibility—and Governor Romer, I appreciated your chart because I think it does make it clear—that in terms of this umbrella that you at least have a clear limit on what can happen.

It can only happen if you have got more people that are eligible. As I listen to you, in your bill you cannot become eligible because the State simply says more people are eligible. There has got to be a change in the population, that at least we assume is triggered by something beyond the State's control.

I think, given the obvious concern that States have about being in a position where they have got a fixed amount of money and they have got a responsibility they have got to perform, I think if we decided to go in the direction of having an umbrella, that this is about as reasonable a way to do it as you could have.

Senator GRAMM. Thank you.

Governor ENGLER. Senator Gramm, 33 percent of this committee are agricultural economists. Governor Romer, as an agricultural economist, drew that chart knowing that you would immediately take to it. [Laughter.]

Senator GRAMM. Well, I was impressed, though he did not label the axes. [Laughter.]

Governor ROMER. I have learned that you get along further in bipartisan efforts if you avoid labels, Senator. [Laughter.]

Senator GRAMM. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. I want to join my colleagues in thanking the Governors for their effort. I think everybody here wants to reform welfare and Medicaid and I think most everyone here wants to move toward a balanced budget.

It is very hard to do all these things simultaneously as the Governors, I think, have found out in going through these efforts with us. We very much appreciate the time you have spent. It is hard to bring together these two ships in the night.

I must say, when I look at your proposals, my concern begins to grow a bit because I see a whole series of ways in which there would at least be potential for States to tap into the Federal treasury, while reducing their own efforts. I must say, a block grant starts to look more and more like a blank check when I start to look at some of the details here.

Let me just go to some specifics. First of all, with respect to the additional child care money, the $4 billion, I think we need to be clear on that. My understanding is, the additional $4 billion would

come from the Federal treasury. There would be no State match requirement on that $4 billion for child care; is that correct?

Governor CARPER. The CBO, when they scored the conference report, indicated they thought it was about $6 billion light on child care, about $4 billion of that from the Federal Government and another, roughly, $2 billion from States.

If you look at most States, in Delaware, and probably every State all the way down here to Colorado, we are more than matching the Federal money for child care. We are very intent on moving people to work. In fact, in our State we have completely eliminated, zero, the waiting list for poor families for child care. We are more than spending what we are required to, and my guess is that most States are.

Senator CONRAD. But I am asking a very specific question here. For the additional $4 billion of Federal child care, there is no State matching requirement. Is that not correct?

Governor ENGLER. The last $4 billion, there is no match on. However, there is additional child care money over and above current law which is required to be matched.

Senator CONRAD. No, I understand that.

Governor ENGLER. All right.

Senator CONRAD. But on the $4 billion that you have layered in here——

Governor ENGLER. The last $4 billion; that is correct.

Senator CONRAD. There is no State matching requirement.

Governor ENGLER. That is correct.

Senator CONRAD. Let me just say to you, from a Federal perspective, that looks an awful lot to me like tapping into the Federal treasury for money, and you guys are not putting it up.

With respect to ending restrictions on provider tax schemes, you know, we had a bitter experience here with some States tapping into the Federal treasury with provider tax schemes to increase the Federal pay-out to them, and it did not do anything for the vulnerable people who were supposed to be helped. What it did, was help State treasuries.

Now, I do not see anything that prevents States from re-engaging in that kind of scam. Is there something here that prevents States from doing that?

Governor ENGLER. I believe there is. The new structure—you have the new formula funding model—changes rather dramatically the States' and the Federal roles. I believe the Federal role becomes a much more predictable one. I believe that the State, with the flexibility that it has, is simply in a situation where it will use the dollars available in a different fashion, a more flexible fashion.

So your base, the way that is structured, all the gaming incentives disappear. DSH, as Governor Romer pointed out, virtually disappears over time because it is a shrinking part of a growing base, in effect. So I just think the incentives now are changed.

I believe that moments ago you were concerned that States were not putting up enough money, and now we are into a discussion about how it is that States have to tax.

Senator CONRAD. No, no, no. You know well what happened with respect to some States. I am not going to level the finger at anybody here, and I am sure none of you would engage in it in the fu-

ture. But we all know what happened. I mean, there were these schemes where they would level taxes on providers and redirect the money to the providers so they were not out, and be able to qualify for more Federal funds. Some States did it to a fare-thee-well.

Governor CHILES. Senator, I think the short answer to your question is, there is no protection in here to keep States from being able to go back and do that same thing. I would point out to you that the six of us did not put that provision in, that was added in sort of a preliminary session in which Governors from both sides, both parties, decided that they wanted to put that in. I would say that you have put your finger on something that this committee and the House ought to look at very, very closely.

Senator CONRAD. Let me just say this to you.

Governor THOMPSON. But, Senator, if I could just——

Senator CONRAD. Let me just complete my response to Governor Chiles.

Governor THOMPSON. All right.

Senator CONRAD. Let me just say to you that, in terms of being able to pass something, it cannot just be a wish list sent up here by Governors. I mean, that is not going to pass.

Governor CHILES. We understand.

Senator CONRAD. It is not going to pass to have a circumstance in which States can scam the Federal treasury. My own State did not do it, and I commend my State for not doing it; Tommy, I know you did not do it. We know some States did. That is not going to pass around here.

Governor THOMPSON. But, Senator, can I quickly just respond?

Senator CONRAD. Yes.

Governor THOMPSON. There is no longer a disproportionate share program, so there is no reason to be so concerned about it. The disproportionate share program is where States did this. We did not do it in Wisconsin. Maybe I should have, but we did not.

Senator CONRAD. Yes.

Governor THOMPSON. But in the future, you have capped the disproportionate share program.

Senator CONRAD. Right.

Governor THOMPSON. And we are now bringing it down through this policy. So I understand where you are coming from, but it really is not an issue.

Senator CONRAD. Well, let me just say this in conclusion.

Governor THOMPSON. Sure.

Senator CONRAD. I have identified here four places where I can see very quickly how States could engage in the same kind of gaming. Maybe it is completely inadvertent. I could go through those with you. I do not have the time right now, but I would like to submit these to you in writing.

Governor THOMPSON. I would appreciate it. I would appreciate it.

Senator CONRAD. I would like to have a chance for you guys to react. I am sure it is not the intent. I just want to make certain that is not where we go.

Governor THOMPSON. Senator Conrad, we are so concerned about getting something passed, we want to help you, we want to work with you on a cooperative basis. You see some problems with it, send it back to us and the six of us, in a bipartisan basis, will look

at it, try and come up with some sort of reasonable solution that you can support, and hopefully we can get this off of dead center.

We are really not here to game the system, we are really here to pass a Medicaid program that will work, that will take care of the poor, and be able to help States develop a more efficient program.

Senator CONRAD. I would be glad to submit these areas where I think the system could get gamed so we make sure that is not the result.

Governor MILLER. We have had discussions specifically that we want to put in prohibitions against gaming, except at the tables in Las Vegas. [Laughter.]

The CHAIRMAN. Thank you, Senator Conrad.

Senator Simpson?

Senator SIMPSON. Well, I want to add my peon of praise to all of you. I have come to know you, some of you, quite well. I really do appreciate your efforts. We should have a serious reliance on what you are trying to tell us.

You, I think, are the promise of whether we get anything done because of the situation here. I want to commend Senator Chafee and Senator Breaux, who continue to work very hard on a bipartisan effort to try to get something done in the broadness of these areas.

But this one is a tough one, because we passed the welfare bill by a big bipartisan vote. It was a good welfare bill, we thought. Then it got all tangled up after it got out of here, and we know the politics of that.

The issue of Medicaid. We did a gutsy effort at that, and that got all tangled up. It all is marvelously portrayed as doing something evil to the children, and the elderly, and the poor, and the veterans, you name it. It just freezes us in place and we get nothing done.

Yet, here we are giving you instructions about picking up some slack, and all of us here will vote in a very few days on a debt limit of $5 trillion. If we get done all the evil things that are being portrayed by those of us in my particular faith, politically, when we are all done, in 7 years the debt will be $6.4 trillion.

It is really brainy stuff that we are up to here, because it is $5 trillion now and it will be $6.4 trillion in 7 years after we have done, if we got away with it, everything that those in my particular faith, politically, would do. I mean, it really is startling.

So when we say you are supposed to look after the State treasury, we are supposed to look after the Federal treasury and we have failed in that totally. Totally. There is no way to get back, unless we do something with Social Security. [Laughter.]

Senator SIMPSON. I have hearings on that and it looks like a bowling alley at 2:00 a.m. in the morning, just stark. Just a great shaft of empty chairs. [Laughter.]

We all know Social Security is going to go broke, because the trustees are telling us that, and Medicare will go broke. So it seems such a feckless exercise to wonder what you are doing, when there will not be any way for us to help at all in the future, and within the near future.

I am talking about 7–15 years, period. Bob Kerrey and I worked on these issues in a bipartisan way, John Chafee and John Breaux work on it in a bipartisan way, and maybe we can get something stirring. But these are the real issues.

I guess, finally, some of the interest groups—and I have seen some of the testimony from the House; I think you have all done a tremendous job and I commend you all—come in and claim your proposal will allow the States to dramatically reduce things to the most vulnerable sectors of society, and then they trot out the usual horror stories, how do you really respond to that and try to keep a degree of equanimity that would be becoming of a chief executive of a State? How do you handle that, Roy?

Governor ROMER. Can I start and answer on that?

Senator SIMPSON. Yes.

Governor ROMER. This is a work-in-progress. There are certain things that we have not yet completed. Amount, duration and scope needs further definition; the issue of definition of disability is not yet done.

Unfortunately, because this is a work-in-progress, people have taken the language that is preliminarily laid on the table, six pages, and you cannot rewrite the Medicaid law in six pages. Quite often they will take a gap like that and carry it to the extreme.

I just think, Senator Simpson, that over some additional time we will be able to close in on some of those areas that are not fully described. I think there is a basic commitment among the six of us that we are going to make a guarantee to the existing mandatory populations and mandatory benefits. I just think it takes some time to close some of those gaps.

Governor CARPER. Senator Simpson, there is an old saying—it may be your old saying; I do not know—people may not believe what we say, they will believe what we do. If you look at Delaware, or Michigan, or Wisconsin, or other States—in Delaware, in our welfare reform plan, when people go to work, we help them with child care. As I have said earlier, we have eliminated completely the waiting list for child care for low-income families in our State.

In our State, when people go to welfare we say, what kind of message have we sent for years to people on welfare? You stay on welfare, we will provide you with health care; you go to work for somebody who does not provide health care for you, and we are going to forget you. No wonder people stay on welfare.

What we have done in my State, and I know is being done in other States, when people go to work in Delaware and their income does not exceed 100 percent of poverty, they remain eligible for Medicaid indefinitely. If their income exceeds 100 percent of poverty, we will let them remain eligible for Medicaid for two full years.

In my State, we changed the income tax laws this year so that people whose income is essentially less than the rate of poverty do not pay State personal income taxes. We want to take away the disincentives that keep people from working. We want to provide incentives for people to go to work, and give them the tools. Look what we are doing. Just look what we are doing. And it is not just Delaware, it is many of the other 49 States as well.

Senator SIMPSON. John, did you want to respond? I am not asking another question. You can finish.

Governor ENGLER. If I can. To the apologists of a failed system, which I think many of these advocacy groups are, I challenge them to give us a plan that is a better plan than the current system.

Everyone from the President on down in America believes that the current welfare system is a failed system. I say everyone; I realize some of these groups do not. But I think the burden then is on them, because they love to be in the second-guessing seat.

They will point out everything that may be a weakness with the change that is being proposed, while they defend a status quo which is clearly not working. I just do not let them shift that burden of proof. That is what they do, they try to shift the burden of proof and let the perfect be the enemy of the better. This is clearly better for poor people, for elderly, for disabled, for pregnant women, at-risk children, than the current law; no question about that.

Senator SIMPSON. Well, I would think it would be tough to have it called a race to the bottom. That is absurd, in my mind. I admire what you do, all of you, and commend you. Thank you very much.

Governor ENGLER. That particular charge is easily rebutted by the fact that 62 percent of the Medicaid spending today is on optional services. If we wanted to race to the bottom, we have got a lot of money today that we have the flexibility to start that race. We have not done that.

Senator SIMPSON. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Nickles.

Senator NICKLES. Mr. Chairman, thank you very much. I would like to compliment the Republican Governors and the Democrat Governors for coming together. I have worked with quite a few of you, and I think you have done a remarkable job, and hopefully you have given us some momentum to complete the job. I hope that we have not gone through all these meetings this year and end up with nothing. I think that would be a real shame.

I really think that your proposal may be the instigator for helping us put together the entire package, not just on Medicaid and welfare. Those are two of the more controversial components, but the others, frankly, are Medicare, and the outlay differences are miniscule between the last proposals on outlays on Medicare, there are some differences on Part B, and some differences on taxes.

But I hope we can come to an agreement that would lock in the best we can do this year. I think you have given us a real positive mood, both in welfare and in Medicaid as well.

Let me just ask a couple of very quick questions. In terms of savings, what does the proposal have? Do we have CBO's scoring on what the savings would be under either of these proposals?

Governor THOMPSON. We do not as of yet, Senator. We went in with the understanding, the six of us, and Governor Carper on welfare, that we would try to develop the policy, and that the Senate and the House would have to determine exactly what savings that they wanted to put in.

Governor MILLER. Can I add, Senator, the mechanism for the savings, if you look at the chart that Governor Romer drew, is the second component there, which is the inflationary index, the cost

index, and that can be adjusted to reflect whatever is necessary to get to the particular target numbers.

Senator NICKLES. All right. My compliments.

Let me ask you, on Medicaid, we wrestled with this when we were working on our original budget proposal. We got into the question of disability and whether that would be an entitlement. As I understand it, you consider disability an entitlement. Who determines qualifications or eligibility for disability, is that a Federal determination or a State determination?

Governor THOMPSON. State determination.

Governor MILLER. But that is the question, along with amount, scope, and duration, about which Senator Rockefeller asked in the course of his questions, is the area of the controversy that Senator Simpson just mentioned. Let me outline what we discussed earlier. The State defines both of those. However, the Secretary must approve the State plan.

Additionally, under orders to enforce the guarantee, an individual has a right, through State administrative and State court, but the Secretary has a right to Federal court on behalf of any individual or on behalf of any class of individuals, maintaining the Federal involvement, both in the approval of the plan and the right to take a court case.

What is something that we are still in the process of discussing is, what criteria do you utilize to establish what the Secretary's role is? In other words, the Secretary's approval is meaningless unless you have established some basis for that, and his or her right to take a course of action would be in the same category. That is something we are still working on.

That is the area that causes concern by some, or at least they use it as the reason that they are afraid that there is going to be a diminishing of services. We specifically included under the guarantee every single group in both the mandatory and optionals, with very limited exceptions. So almost in any State anybody who presently gets it is guaranteed to continue to get it. What they are continued to get, obviously, is within that parameter.

Governor CHILES. In disability, also, Senator, we had a set-aside; you had to spend at least 90 percent of what you were spending before, so that would keep you from just saying, we are going to not——

Senator NICKLES. It is not going to be devastated.

Governor ENGLER. Senator, there has also been some criticism, as you are aware, I am sure, that why should we let the States define disability? Our policy is very clear. It just says, simply, "persons with disabilities, as defined by the State in their State plan." The criteria that was mentioned, I mean, the reason we are discussing that, that could cut both ways.

A Secretary could be quite arbitrary, so there is an interest on some of who support the State definition. But why the States? We are allowed currently, under Worker Compensation laws in this Nation, to define, what is a disability for every working citizen in this Nation.

So the argument is, if we can be trusted to do that for the majority of Americans, then should we, and could we not be also trusted

to do the definition of disability for those who are not working because of a disability?

Finally, Congressional policy would seem to support in the past the State right to do so because of the grandfathering in of other States, and there still remain 11—I think there were recently 14—who are not under the SSI definition.

Finally, the Federal record on SSI definition is not laudable, given the presence of alcoholics and drug addicts for a number of years. Under any State Governor in America that I am aware of, they would have been chopped off immediately. So, that lack of flexibility is, again, a cost barrier.

Senator NICKLES. I appreciate that. I am about out of time. Let me ask you a quick question.

I think there is bipartisan support for repeal of the Boren Amendment; is that correct?

Governor THOMPSON. That is correct.

Senator NICKLES. Could you give me a brief explanation of why that is necessary?

Governor THOMPSON. Well, the Boren Amendment is causing untold amounts of litigation, it is driving up costs. Providers are going into one State, then taking their conclusion from that lawsuit into another State. Every time you try and put together your budget——

Senator NICKLES. Does it mandate what an adequate level of care is?

Governor THOMPSON. The court-established floor. The National Governors' Association, in 1981, were the ones who were pushing this. They thought it was going to be the ceiling. What happened is, HCFA and the courts have interpreted that and there have just been a plethora of lawsuits across this country and it has been driving up our costs. We have no control over that. The courts are determining what we are going to pay our providers.

Senator NICKLES. Thank you very much. Mr. Chairman, thank you.

Governor THOMPSON. The repeal of the Boren Amendment is probably the most strongly considered by all Governors. If nothing else happens, please repeal that.

Senator NICKLES. I thank my colleagues.

The CHAIRMAN. Thank you, Senator Nickles.

As a number of you have indicated, the proof of the pudding is whether or not we will get legislation enacted and signed by the President. I wonder, has the bipartisan group of Governors gotten any signal from the White House as to whether or not they approve these two proposals?

Governor MILLER. I think, Senator, that at the time that we agreed amongst the Governors, moments later, or actually in the middle of that process, the President addressed us, and Senator Dole had addressed us earlier that morning. I think both of their comments were very similar, that they were supportive of this idea, that they are supportive of the concepts.

The President expressed some areas of concern, the T and EPSDT, and the definition of disability, and there might be other concerns that the White House will certainly want to bring to your

attention. But, as a general concept, they have been supportive, and so has Senator Dole and others in leadership as well.

Governor ROMER. Mr. Chairman, could I add to that answer?

The CHAIRMAN. Yes, please.

Governor ROMER. It is important, I think, that we flag the problems that really need further definition and further work. We have done that, in part, this morning, such as the definition of disability, the issue of amount, duration, and scope, the provider tax. But let me put one other on the table, because it is one that has been raised by the White House.

It was the change of the matching rate by States from 50 percent to 40 percent. Let me describe how that happened. In the six Governors' negotiation, we did not make that recommendation. That came off of the floor of the 50 Governors.

Colorado now makes a 50 percent contribution. It was said, we can reduce that in Colorado to 40 percent. I think it is a serious question that needs further investigation.

I think you can tell, it is in the self-interest of States to say, sure, reduce our matching rate. But I think in scoring you may find that that cost will be approximately $200 billion over the 7 years. It could be that much.

If you go to the formula that we described, and the formula is based upon trying to arrive at what it costs to serve the current population in an existing base year and changing that with a percent inflator year by year, if you then come in with a lowering of the FMAP, the Federal match, then you have got to ask the question, what is going to happen to fill that gap?

Are States going to voluntarily continue to make it even though it is not mandatory, or are they simply going to take that out of the system? The reason that is so crucial is that that formula was arrived at to give greater flexibility to the States to move categorical funds into innovative programs. If there is another door, that you do not need to do that, but you can just take it out and take it home, that is a serious policy question.

Now, I agreed to that as one of 50 Governors, as part of a compromise package. But I come to the table with a self-interest in terms of my own budgetary requirements. I just want to flag that. You need to give that some serious consideration.

Governor CARPER. Mr. Chairman, the President and the administration are certainly capable of speaking for themselves on how they feel about what we have put forward, whether it is on Medicaid or welfare reform.

Our President has consistently said that we should change welfare as we know it. He said we should replace it with a system where the benefits are transitional, where they are time-limited; this is.

The President said we should adopt a system where we reward work, where people who go to work are better off than those who are on welfare; this proposal does that.

The President has said that one of the greatest failings or shortcomings of the 1988 Welfare Reform Act, which some of us here worked on, was the inadequacy of child care; we addressed that concern.

I will certainly acknowledge the concerns that Senator Breaux and Senator Conrad have raised, and others, with respect to whether or not States should match those dollars, but I think we addressed that concern.

The President said that both parents have a financial obligation to meet the needs of their child; this proposal does that. The President said we ought to——

The CHAIRMAN. My time is almost up before I ask my first question.

Senator SIMPSON. We will give you another five minutes.

The CHAIRMAN. I appreciate the fact that the President has a broad bipartisan consensus. We are all interested, and think there is a need to reform welfare.

My question was directed at whether or not the signals indicate if the White House is satisfied with this particular proposal.

But I would like to go back, briefly, to this question of flexibility. One of the four primary goals of the NGA proposal is, "States must have maximum flexibility in the design and implementation of cost-effective systems of care."

Then it goes on, "In the areas of benefits, the proposal states that States have complete flexibility in defining amount, duration, and scope of services. Yet, as we have pointed out, the NGA proposal calls for the Secretary to approve the States' Medicare plan."

So I would like to go to the question, if the States have such flexibility, what criteria will the Secretary use to evaluate the State plan?

Governor MILLER. As I said moments ago, Senator, that is basically something we are still discussing. We recognize that there has to be a threshold. We have not concluded what is an appropriate threshold, whether it is existent policies, whether it is an exterior source like commercial health care programs, whether it is Medicare formula.

We have not concluded what makes the most sense, but we have recognized the question that you are stating, and that is that there has to be some criteria for that level of involvement.

Governor CHILES. Mr. Chairman, one of the things we are looking for is some way to get away from the number of lawsuits that we have. The providers are suing us constantly and saying, you know, you did not provide enough, and you have to spend more.

If you look at our budgets, we are spending an inordinate amount of money on certain kinds of maladies, and are unable to really take care of poor people because all of those dollars are going out the window. So, what we are seeking is flexibility.

At the same time, we recognize that the critics will say, if you have total discretion in amount, duration and scope, well, what that means is the Governors will just say zero days, zero this, zero that, and that will be the way that they will keep anybody from getting a meaningful benefit package. That is not what we are about; that is why we put in to allow the Secretary to have to approve that.

Now, everybody kind of recognizes that there needs to be maybe some standards, but our concern is that we do not get back into the box, where HCFA and the providers can just drive us crazy, the endless time, the lawsuits.

It takes all of the money of our red tape in doing that, so we ask for the committee's help in trying to get us to the intent of where we are, and that is to allow us more flexibility in how we run our program. At the same time, we want to give that meaningful benefit package to the people that are in need.

The CHAIRMAN. Well, I think this is a critical question, because if you are going to have flexibility there is a serious problem in how you define the criteria by which the Secretary approves or disapproves. As I understand it, Lawton, one of the concerns I think you had—correct me if I am wrong—is that HCFA has been very burdensome in its administration of the program and created considerable problems.

In fact, I think there is a Governors' statement, and it is a strong statement, that "States must be unburdened from the heavy hand of oversight by the Health Care Financing Administration." The proposal also states that, "The plan and plan amendment process must be streamlined to remove HCFA from micromanagement of State programs."

Governor THOMPSON. Mr. Chairman, could I just very quickly respond to that?

The CHAIRMAN. Yes, Governor Thompson.

Governor THOMPSON. Right now, people do not understand what we have to go through. It is like hell. There are 15,000 pages of law, rules, and regulations that we have to comply with. There are annually 8,000 reports that we have to file, and there is not one person that ever looks at those 8,000 reports. There are 50,000 pages of State plans that are filed annually by the States.

If we want to change our State plan, we have to get an amendment and that has to be filed. Then if we ask a question, they say we have to go through the 8,000 reports that have to comply with the 15,000 rules and regulations. And that is just nursing homes. [Laughter.]

That is the dilemma. We are saying, give us a chance. We will give the Secretary a chance to prove it, but allow us to have some amendments. Then when we ask HCFA if we can get our amendment adopted, they will send us back 100 questions because they have not got time to process the 8,000 reports.

The CHAIRMAN. Let me ask this question. Is this a bipartisan concern; has this been the experience of all the Governors?

Governor CHILES. Yes.

Governor MILLER. Yes.

The CHAIRMAN. There is no question about that.

Governor ROMER. Mr. Chairman, let me respond, as a Democrat. It is obvious that we need to have more flexibility, but you can abuse the phrase of complete flexibility on amount, duration, and scope. You are right; the safeguard was approval of the Secretary.

I think you are also right that we need to get further definition of that. We are now discussing it. Just for example, you might define the minimum amount, duration, and scope as the most standard, basic HMO package within your State.

For example, there are other ways, but I think you should know that we need to close that area because right now we stand being criticized that we have absolutely removed the guarantee. Unless

you close that area, you really do not have, I think, an understandable and reliable guarantee. But it can be done.

The CHAIRMAN. Well, I just wanted to underscore the importance of reconciling these differing, legitimate, but somewhat inconsistent goals.

Governor ENGLER. Mr. Chairman, if I can just maybe get in the last perspective on that.

The CHAIRMAN. Yes.

Governor ENGLER. It is a little bit different, because, in terms of this document, there was an awful lot of give and take among the Governors. This phrase is very, very important in terms of having the complete flexibility in defining amount, duration, and scope of services because in the past what we have had is, I do not want to say a dual standard, it is really a 50-State standard going on at HCFA.

In other words, some States can do something, but other States cannot. For similarly situated States, one is allowed to do something, the other one is not. What I do not want to have is a Secretary say, well, you know, we deem Wisconsin to be more well-off than Colorado, so Wisconsin, your basic services will be at this level, and Colorado, you can be down here. That is not fair, in terms of fairness. So there is an effort here, as we have talked with the guarantees, that there is a national framework here, a national set of guarantees.

So if someone is going to take care of a pregnant woman, presumably the pregnant woman has the same need in Colorado as they do in Wisconsin, therefore, the standard would be a similar standard.

What we do not want is to say, well, they are from Wisconsin and they can afford more, so we will put them up 20 percent above Colorado. That would be wrong, and that would not be complete flexibility. That is what will be a point in this thing.

Governor ROMER. You could benchmark it to the program Congress has.

The CHAIRMAN. I am sorry, I did not hear you, Governor.

Governor ROMER. One other way to go would be to benchmark it to the health care that members of Congress have.

Senator SIMPSON. Why, you.

The CHAIRMAN. I am not sure you want that.

Governor ROMER. We do not, Senator.

The CHAIRMAN. Well, we look forward to working with you, because I think this is a critical point in your proposal.

Senator Breaux.

Senator BREAUX. Just a couple of questions, Mr. Chairman, on Medicaid, which is what we are talking about. In talking about what we are all trying to achieve, basically, I think, we are trying to guarantee basic health benefits for the people in our States.

I think, in discussing this with my staff, in order to do that it is sort of like a three-legged stool. I think you have to have a guarantee of who is going to be eligible; second, a guarantee of what they are going to be eligible for; and third, some type of a right of action to assure that these guarantees, in fact, occur.

Now, on the right of action, I am not really hung up on the fact that you can only get a right of action successfully approved in a

Federal court. I mean, the State courts are there and the benefit packages apparently are going to be involving the States' determination of what it is. So, having it decided on by a State court with some type of ultimate appeal to the Supreme Court, I think, is not a problem for me at all.

But on the first one, the guaranteed eligibility, I note that your plan does not mandate coverage for what the Federal Government is doing now on 12 and above. That is being phased in on the Federal level now. You do not have that, so that is a big area of young kids that are going to be, perhaps, left off that are not going to be guaranteed that coverage under your proposal.

Now, on the second thing, and that is the standard benefit package, of guaranteeing some benefit package, now you have a lot of flexibility on the amount, the scope, and the duration of the benefits. But there is some standard there to which it is measured against, and the standard is a package that is sufficient to achieve its purpose.

If you knock that general standard out, well, then you could have a package and there is nothing to judge it against. That is the concern, I think, that some of us have. We have a package on which you can determine the amount, duration, and scope, but what is the standard as to whether it would be an adequate package or not?

Governor CHILES. You are exactly right, John. We know that we need that. As we said, we are trying to wrestle with that. We need your help, and that will ultimately be your responsibility to do.

We would sort of urge you, if you put in some words like medically necessary, then you take us right back to the courts. That is what has happened. What is medically necessary? You get a Federal court that says the sky is the limit is what is medically necessary, that you give a liver transplant to somebody that is dying or something else, and then everybody has to do that.

So what we would urge is, look at some other standard, like, what is the standard benefit package that is out there for your workers? Give us some standard that is more measurable that way, that it is not so subjective that, through Federal courts or HCFA, it could just balloon on us.

Governor THOMPSON. Senator, can I quickly respond to both of those points? We are working on that. We came in on Tuesday night, and we worked till midnight. We worked yesterday, and we are going to go back and work this afternoon. We are looking at some way. Just do not give it to the Secretary or put some general language in there that would bring us into court, as Lawton has said. Tie it to maybe the minimum HMO policies in our State, or something like that. We can live with that, and we think we can come up with that.

The second part of your question was on the children from 13–18, which are phased in on an annual basis. That may be true for some States, but other States like California, Florida, and Wisconsin, what we are trying to do is we are trying to expand our coverage to the working poor. We think that is a much better population that we should be extending benefits to, and we cannot do that.

So I think it goes back to the old argument of, one size fits all just does not work. Some States will do the 13–18, other States—like Florida, I think, want to try it, and I know I want to try it—want to expand the base so we can cover more people, especially the working poor, under the Medicaid program.

Senator BREAUX. Have you all come to a conclusion or recommendation on the guaranteeing of State-wide comparable benefits for all of the eligibility groups within the State?

Governor ENGLER. Again, when we talk about flexibility in terms of scope of services, just take Michigan, for example, the upper peninsula of Michigan is very different than, say, southeastern Michigan with the University of Michigan Hospital in Ann Arbor, the Detroit Medical Center complex. So, there are different approaches that we think are appropriate in a State.

That has been one of the restrictions in the past, that it has actually cost both Federal and state taxpayers excessive money and done very little in terms of benefit costs. So, we would look at structuring, maybe, an HMO in northern Michigan slightly different than it would be in southeastern Michigan.

Governor MILLER. We are still trying to refine the language on that.

Senator BREAUX. Can we hear from Professor Romer here?

Governor ROMER. Oh, no. No professor.

Senator BREAUX. You did the blackboard; I thought it was great.

Governor ROMER. We ought to have ideas here on the table. Obviously, the compromise of the 13–18 is one that was made. Some of us had a different point of view personally, but we made a compromise. But you should think about, as you put this all together, another approach.

That is, under this formula, anything that you add optionally from here on you do not get further pay for, it is just a part of your flexibility. If you wanted to maintain an attractiveness for States to pick up the 13–18 who have not done so, you would say, all right, you can do it and you can now count that group as a part of the base. That is another mid-position.

Senator BREAUX. Can I ask one quick question on the question of disability? The Slattery Commission has done a lot of work on this, and I thought it was very helpful for what they were recommending on definition of disability.

I take it you all are suggesting the State defines what disabled is, so you could have 50 different definitions. I mean, is what the Slattery Commission recommended not major improvements? I mean, children who misbehave are not necessarily disabled; we tried to correct that. Drug abuse is a voluntary disability and they should not be rewarded for it. That is their recommendation. I thought they were pretty solid. I am concerned about 50 different definitions of what is disabled.

Governor THOMPSON. Right now, Senator Breaux, under the 209–B States, you grandfathered in back in 1971, 14 States that have their own definitions on disabled. Mike Levitt did a search, and there are 873 different definitions of disabled right now, under the Federal rules.

Senator BREAUX. Well, that is wrong. I agree with you on that; it is stupid.

Governor THOMPSON. What we are saying is, give us an opportunity to develop something and we will set some standards and we will come back to you. We are still discussing this, the six of us are, but we think that we can come up with something that will comply. But do not lock us into the Federal definitions.

Senator BREAUX. All right. The final point is, you are going to try and make a recommendation that would become a national disability standard instead of having 50 different ones? I mean, going down from 1,400 to 50 is still nowhere near.

Governor THOMPSON. No.

Governor MILLER. No. What we are trying to do is set a threshold component for the Secretary's approval, just like we are in amount, scope, and duration. But then flexibility is part of that.

Governor ENGLER. Some of us are very wary on that because, again, this was a key part of the compromise in terms of the give and take in this. The nervousness is that this thing gets out of control again and we invite somebody in to start defining what the national is going to be, and one court will see it one way, and another one will see it differently.

I go back to the Worker's Compensation system. We have 50 different State standards there, and nobody has tried to federalize that and say, hey, it is different in Louisiana than it is in West Virginia, we ought to make it the same.

Senator BREAUX. But that is State money.

Governor ENGLER. It is State money.

Senator BREAUX. That is a big difference.

Governor ROMER. Could I be very precise about that compromise? There are some of us who wanted to maintain a Federal definition, there were others who said it must be State. The compromise was, it will be State, but shall be approved by the Secretary as a part of the plan. Let me tell you, at the end of the day you may find that, rather than have the Secretary have that kind of discretion, you want to redefine a Federal standard.

Governor CHILES. But all of us want to see some change from the terrible thing we have got now.

The CHAIRMAN. But where?

Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Just briefly, I share the concerns that were voiced by Senator Conrad regarding the repeal of the restrictions that we currently have in law dealing with provider taxes and donations, all associated with the DSH. You are going to address that, as I understood in your answer to Senator Conrad. You recognized that the problems that arise there, we had restrictions on the provider taxes and donations, and you have eliminated those restrictions in your proposal, as I understand it.

Governor ENGLER. We also eliminated DSH, Senator. So we think that the possibility for abuse is eliminated. DSH is locked into the base and you do not have that as an ongoing problem. That is the point that I tried to make, but I guess not very clearly.

Senator CHAFEE. Well, I was out, and I might have missed that.

Governor ENGLER. Oh. Senator Thompson had clarified what I was going to say, and did it nicely.

Senator CHAFEE. All right.

Governor THOMPSON. There is no longer a DSH payment. The abuses were to get into the Federal treasury, Senator Chafee, and to use the provider taxes to get a bigger match from the Federal Government. That is no longer the case. On top of it, the DSH payments are starting to come together, they are starting to compress, because we are limiting them to 12 percent growth. There are no States that are above that. So States like Wisconsin that did not have any DSH payments coming in—we were fools that we did not try, but we did not—now we will have a chance.

Senator CHAFEE. All right.

Governor ROMER. Senator, can I add to that? I think that this is one of the compromises that was made by the 50 Governors. I think it is a question, in terms of gaming this system, whether it is in the old DSH problem or in the new formula, you have to have on your table. I will confess to you, I, as a Governor, gamed that system under DSH.

I hated it, but I had to do it, because if everybody else was going to go tap the treasury that way, I was going to do it for my State of Colorado. I did not like it. I think that we now have made some changes in DSH, but there are still those that are below 12 percent that have to rise to 12 percent. I am a part of an agreement in which we said what we said, and that is, take it off.

Senator CHAFEE. All right. I want to go to my next question. All I know is, you got into it reluctantly and not with the skill that Senator Gregg did as Governor of New Hampshire, who, as I understand, ended up with 50 percent DSH payments, setting a standard.

On the amount, duration, and scope, obviously, if you do not provide something for the disabled, then going to having the Secretary of HHS come in and determine that you are doing it right—you have discussed this and you are trying to work this out, but obviously you have got a problem here. You may have confidence in the Secretary, he or she, but if she has got no standards to go by, you have not got much. You have got all the worries that you currently have before a Federal judge.

Governor THOMPSON. There is a provision in our policy that says we have to spend 90 percent of the dollars on the disabled, though, Senator.

Senator CHAFEE. Yes.

Governor THOMPSON. And it is restricted to that. Second, we are still talking amongst ourselves about setting a minimum HMO policy, minimum commercial policy in this area. We are discussing and trying to come up with the right recipe.

Senator CHAFEE. All right. Now, let me ask you a question about, as I understand it, you seem to have repealed the comparability requirement. Senator Breaux briefly touched on this, and I think Governor Engler did.

In other words, you do not have to cover everybody in an age group, for example, or in a geographical group.

Governor ENGLER. We have to cover them, but maybe not exactly the same way.

Senator CHAFEE. All right. Now, let me ask you this, and this is kind of an absurd, perhaps, suggestion. But, under your flexibility, you can cover individuals up to 275 percent of poverty. That is

$41,000, which is a family of four. Is it possible, under the proposal you have made, that you could have your State employees making less than $41,000 health care coverage paid by Medicaid? In other words, you would say, because you have repealed comparability, that you could take a group—I am not saying this is so, I am asking the question.

Could you take a group like your lower-paid State employees for whom you provide health care, presumably, and you say, all right, I am going to move you folks, you are less than $41,000, over under the Federal Medicaid program. Is that possible?

Governor ROMER. It is possible. It is absolutely possible. This was designed to give flexibility to States, so it is absolutely possible. It is an option. Now, here you need to——

Senator CHAFEE. I mean, what would make it attractive would solely be the absence of comparability. In other words, if you had comparability where you have got to do coverage for everybody in this category of income, then you would not do it because it is so doggone expense. But if you do not have this comparability, you could target different groups, I suspect.

Governor ROMER. Excuse me. I would let my colleagues answer, but let me say you can do it whether or not you have comparability because under this new proposal a Governor or a State has the option to withdraw from optional eligibles and optional coverage and to use those savings for other classes up to 275 percent.

Senator CHAFEE. No. My time is up, but let me just say this. I do not think you could do it under the existing law because obviously you would have to take everybody. In other words, you stop now at age 12. You do not go above that. If you went up to this family of $41,000, you would have to cover everybody in your State. You could not pick and choose, under the existing law.

Governor ROMER. That is correct.

Governor ENGLER. I actually do not think, Senator Chafee, that it is possible to take somebody who has currently got coverage and drop them. I am not sure how you would do that. I mean, they are not exactly uninsured. Maybe you say, at the stroke of midnight on this date the old contract expires. Our cases are collectively bargained, so it would not matter anyway and I suspect we would not get approval on that.

The real goal here is to do the kinds of things that we have done, and other States are contemplating. We cover all children. For example, the question raised by Senator Breaux earlier. We take the children up to 17 up to 185 percent of poverty. We call it our Healthy Kids initiative.

We are trying to take people who have left welfare and currently are entitled to Medicaid coverage for 1 year after they leave the program and try to create a buy-in opportunity or something for year two and year three, because we do not want them falling back into the welfare system once they have left. All of these are flexible provisions. Some of the groups who oppose the flexibility and want the rigidity coming out of Washington would say, let me give you this hypothetical.

But I guess our problem is really on the other end of the population, and many of the critics try to pick out sort of the anomaly and say, this exception could become the rule because we want to

derail the reform and keep the current system which we love so much.

Governor THOMPSON. Senator, if I could just respond.

Senator CHAFEE. Do not put me in the category of loving the present system.

Governor ENGLER. Oh, I do not; not at all.

Governor THOMPSON. Senator.

Senator CHAFEE. Yes, Governor Thompson.

Governor THOMPSON. Senator, we have come up with a policy, and we worked very hard at it, over 100 hours of face-to-face meetings here in Washington, DC. We have not been able to get into every detail. This is not the intention of the policy, your question is.

Senator CHAFEE. Yes.

Governor THOMPSON. But I think the wonderful thing about this hearing is, and the willingness for us to work together in a cooperative basis, is to find the problems and come up with a solution. That is why we want to stay in tandem with you, in cooperation with you. We want to push this forward. We have got a basic policy that is very good, it improves upon the system.

It would help the taxpayers, help the States, and I think help the poor, the children, and the disabled, and that is what we are all trying to do. So if you have questions, we will be more than happy to address them in our conference and come back and talk to you. But I think it is important to move this process as fast as we can.

Senator CHAFEE. Well, I certainly agree with you. I agree with everything you said about the Boren Amendment, flexibility, and all of those efforts. We are certainly going to work with you.

Thank you, Mr. Chairman.

Governor THOMPSON. Thank you.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Mr. Chairman, we have heard—and this is basically a question to the Chairman of the full committee himself—an extraordinarily honest debate and presentation of views by six very honorable and honest Governors.

The term "work-in-progress" has been used a number of times. For example, on the provider tax issue: some said it did not exist, some said it did exist. There are differences, then, about the NGA proposal. But in all cases Governors were honest. Then Governor Thompson said. "We cannot get all the details. We are trying to; we have put in 100 hours."

What comes through very, very clearly, is that it has been a remarkably bipartisan process, with people whose States are different, whose Governors' personalities and philosophies may be different, trying to come together as best they can.

Ultimately, however, it does come down to writing the legislation. In fact, one or two of the Governors have actually asked for the committee's help—I think, Governor Chiles, you were one of them—when this is finally done. That is why I raise a question, Mr. Chairman.

I hope that we are going to see this same bipartisanship on this committee. Recent history does not auger well for that. Senator Moynihan, who probably knows as much about this as anybody in the city, has said publicly a number of times that he felt left out

of the deliberation for the conference report on welfare reform; I know my staff did.

I think all Democratic staff felt left out. Now, it may be that Paul Offner, who is no longer with us, went to a meeting; I do not know. But the general consensus is that the Democrats were left out, and the welfare reform bill was written by the Republicans, by Republican staff and Republican members.

That is true, Mr. Chairman. It was not a partisan thing. I am trying to say this in a positive way, and you know my respect for you. But I think this needs to be said publicly, and asked publicly, that we do at least as good a job—and it is going to have to be an even more refined job—as these Governors have done so assiduously.

I, therefore, would ask for a commitment from the Chairman that, as we do this writing of the welfare and Medicaid reform bill—in whatever form we are going to do it—that it be done with staff of both parties from the beginning, and done together.

The CHAIRMAN. Well, I would say to my distinguished colleague that it is certainly the intent of the Chairman to work with all members of the committee, to consult, through the staff, with various people in an effort to develop a bill that does have broad support in creating the Chairman's mark. I think what the Governors have done has, indeed, been a very positive, constructive effort.

We look forward to continuing to work with them because, as the hearing has brought out, there are some difficult questions we face. What I am interested in seeing is reform that can get through the Congress and signed by the President so that it is actually something done on the books.

Senator Hatch?

Senator ROCKEFELLER. My time is not quite out, sir, but, understanding the delicacy of the situation, I yield the balance of my time.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. I want to welcome all of you here. I want to personally congratulate you for working as well together as you have. I appreciate each and every one of you on this panel. Of course, I want to recognize my own Governor, because I think he made a lot of outstanding efforts in developing this bipartisan proposal.

Governor THOMPSON. Very much so.

Senator HATCH. Unfortunately, he could not be here today because it is the end of the legislative session in Utah, as you all know.

Governor THOMPSON. He was with us the last 2 days, Senator.

Senator HATCH. Yes. I know he wanted to be here today. So, I just want to acknowledge that. But I personally respect each of you. I know you each well, and I just want to compliment you.

I feel very strongly about addressing concerns of Native Americans on both Medicaid and welfare, so I hope we can work together to resolve some of those problems. I know that Senators Pressler and Murkowski also have similar concerns.

The outline of the Governors' Medicaid proposal includes a number of provisions that concern Federal court jurisdiction, private rights of action, and related areas that I think may require further

study and refinement. But I am particularly interested, as Chairman of the Judiciary Committee, in exploring some of the implications. One concern is that the proposal provides for only limited rights of action for individuals or classes of individuals for eligibility of benefits.

According to the proposal, this is "designed to prevent States from having to defend against an individual suit on benefits in Federal court." Now, I have a few concerns with the procedures outlined in the proposal.

First, there may be constitutional problems if there were no Federal court review of this Federal statute, whether for constitutional infirmities with the statute or otherwise.

I agree, this is a very complicated area. But my general point is that the Congress has the authority to limit and define the jurisdiction of the lower Federal courts, but has very little authority to deny Federal court review entirely.

I think the proposal may be trying to satisfy this by providing that a process of State court review is topped off by review in the U.S. Supreme Court. Now, I would personally like to see this get further scrutiny to ensure that whatever provision is included would be, at a minimum, constitutional. Could I just have your comments on this particular area?

Governor THOMPSON. We also have the provision in there to allow the Secretary of HHS to be able to bring an action, either an individual action or a class action, in lower Federal court, Senator Hatch.

Senator HATCH. All right.

Governor THOMPSON. If an individual feels that she or he has been discriminated against in Wisconsin, she or she could complain to the Secretary and the Secretary could initiate a Federal lawsuit in the District Federal Court in Wisconsin on behalf of that individual, or a class of individuals. So, there is Federal oversight by the Secretary. All she would have to do is bring that action.

Governor ENGLER. I would just add, Senator, I know you have a close working relationship with your Governor. This is, if I can be presumptive enough to speak on his behalf, an area in which he has felt most strongly about in the entire process, and basically outlined.

So I do not know if he has had any particular review of the constitutionality—that was a question that got brought up in some of our discussions—but I do know that it is the area of the whole package which he personally felt most strongly about and might, I am sure, be willing to discuss with you.

Senator HATCH. All right.

Governor ENGLER. All I would ask, Senator, if the Judiciary staff would be willing to, perhaps, take a cut at this in terms of, if this outline could be made or developed and drafted in the right form, we would be eager to have that. This has very strong support and we above all do want to be constitutional. That would be a very bad thing to have it struck down and then be back into the same old process.

Senator HATCH. We will try to work with you on it if we can.

Governor CHILES. Senator, if, in the wisdom of the Judiciary staff, though they felt that there were problems here, certainly we

would respect that. I think, if for constitutional reasons, individuals still had to be granted some access into the Federal courts, we would hope that providers could be cut off.

Senator HATCH. All right. I think that is all I have. I know a lot of the other questions have been asked. I really, again, express my appreciation for the work you have done. This has been a very tough area for all of us, and especially for you. I hope we can get done what you really, really want to have done here.

Governor CHILES. Thank you very much, Senator.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Well, it has been a very interesting hearing, Mr. Chairman, and I appreciate it very much. It is interesting to hear two former Governors, Senator Chafee and Senator Rockefeller, asking the most questions, and yet you were doing this at one time and you were seeking flexibility, I assume.

Governor THOMPSON. So was President Clinton.

Senator SIMPSON. I think so. Yes, that is right. [Laughter.]

Governor THOMPSON. But he was just a mere mortal Governor.

Senator SIMPSON. Yes, that is right. So we have to pay attention to that. But you know what is going to occur in your own State if you do not take care of these people. I mean, where are we? The media will tear you limb from limb, and the citizens will tear you limb from limb, and they will have a front-page story about Baby John, or whatever it is. That is the way it is. So you are not going to smuggle it out of here as to what is going to occur.

I think that, as I say, you have presented us some very thoughtful material. I have some questions about the performance bonus, whether that pumps a little extra money into the States that have a pretty good economy and the most employment while not doing much for those that are struggling, so I will ask some questions on that later.

Nursing home standards. It is very interesting. I have family of my own in nursing homes, paying for it, and finding that the State requirements are often more onerous than the federal. That is what I am finding in my own State. The nursing home people come to me and say, Senator, how did you let them do this? I said, I do not know; that is not my bag, that is the State doing that. So, I think that is restrictive.

But before Jay Rockefeller would go, I would just say, do not leave. [Laughter.]

I do not want to say it while you are gone. I do not share those views about the partisan aspects in this committee. It is my first time on the committee. This is a committee that has worked very well together over the years with Senators Russell Long and Bob Dole, Moynihan and Packwood serving as Chairman.

It would be unfair, totally unfair, to think that Senator Roth and Senator Moynihan do not work very closely together on these issues. We have had retreats of this committee in a relaxed location that was bipartisan. We have had meetings where the door was open to all. We have had very serious votes, and they have passed by a large number of bipartisan votes.

Senator Moynihan and I are working on CPI reform. If we cannot get that one done, it is absolutely absurd. We work on affluence testing of Part B premiums. If we cannot get that one done, it is

absolutely absurd. Minimum payments to physicians by all people who go to a doctor, $5, $10; that was a good bipartisan vote. There are a lot of them.

I guess the problem is, whenever we attempt to do something it is met with an extraordinary array of the most wretched excess of people dying and children collapsing, and on, and on, and on, so we are just frozen in place. That is the most vexing part of it. It is not the partisanship, it is the attempt to portray that this is really an ugly country, trying to do something to the poor, or the wretched, or the veteran, or whoever, or whoever, or whoever.

If we were that bad, we sure would not have a debt of $5 trillion, with a budget of $1.506 trillion just to run the country for 1 year, and deficits, depending on which figure you are picking, between $200–250 billion a year. So those are the things that make it difficult, it is not the partisanship.

Governor MILLER. Senator, can I comment on that briefly? Maybe it goes to what Senator Rockefeller said. [Laughter.]

I would not be presumptive enough to suggest how the committee drafts any such bill; I do not think any of us would. But, just for your information, we have asked our own staff, in working with either House, to ask for bipartisan representation from the particular committees be present when they work. That is something we discussed just the other day so that we have that sense that there is an equal representation. That has been successful in our process.

As Governor Thompson pointed out yesterday, I believe, in one of our hearings, there are 31 Republican Governors, there are only 18 Democrats and one independent, and yet ours is broken up in three and three, and we have always all been present in equal numbers.

So, whatever the numbers are, at least with our staff we have asked to try and have both sides present so there are no misunderstandings as to what our position is, if that is helpful as a starting point.

Senator SIMPSON. Roy?

Governor THOMPSON. If I could compliment you on one thing, Senator, is your leadership on CPI. The Governors, on a bipartisan basis, applaud you.

Senator SIMPSON. Yes.

Governor ROMER. We have passed a resolution commending you and Senator Moynihan for that.

Senator SIMPSON. Roy?

Governor ROMER. Senator, I think all of you know that we are receiving a lot of fire for the cooperative bipartisan effort we have here. In terms of process, Mr. Chairman, there is a tradition here in the Senate on this issue already of some bipartisan work.

I would hope that, as you proceed with this, at least simultaneously with the House, I just think in terms of getting over some of the polarization, the Senate's past cooperation on it, it could be very helpful. I am really raising the question as to, where does the draft begin, who does the draft, which House does it go through?

Senator SIMPSON. I would say, too, Mr. Chairman, and end, that Senator Kerrey and I continue to work on this package of restoring long-term solvency to the Social Security system and, when we finished our work on the Entitlements Commission, would have

thought, along with Senator Danforth and Senator Bob Kerrey, that reforming the CPI would be like falling off a log. Now, with the senior groups out there going bonkers and the AARP—oh, God, you knew I would get to that, but I certainly would not miss it. [Laughter.]

Here is the AARP—get this one; you do not want to miss this—howling into the vapors about the $7 a month increase on Part B premiums, which is voluntary, and then they raised their monthly premium on their Medigap policy $31 a month. That is the hypocrisy award of all time. I would like to confer it, along with the Order of the Green Weenie, on those guys. [Laughter.]

The CHAIRMAN. Well, the hour is growing late. [Laughter.]

I think all of us are deeply appreciative of what the Governors have done, and particularly their willingness to spend the time here today answering our questions. Rather than have another run at further questions, we will permit them to submit them in writing to you and we would appreciate your answering them.

Governor THOMPSON. Senator, can I ask one question before we break up here this morning?

The CHAIRMAN. Certainly.

Governor THOMPSON. How can we be the biggest help to you and the committee and your staff over the course of the next several weeks to get this thing completed? We are dedicated to get this done, because so many Governors have already put into their budgets some of the changes. It is going to be a tremendous embarrassment and financial reversal for a lot of States.

I guess people do not understand how important it is to reach an agreement on employment and training, on welfare, and on Medicaid, because that makes up one-third of our budgets and we do not know which direction to go if we do not have some laws passed.

The CHAIRMAN. Well, I think working directly with you, but with your staff as well, on a continuing basis is the way to get the job done. We are undertaking the drafting of a legislative proposal. We are working with the House. It will be a bipartisan effort. As I said, I think the goal is to get something that can be enacted in both Houses and signed by the President so that we actually have something on the books. That is my intent.

Governor THOMPSON. However we can help, just let us know. Thank you very much, Senator.

The CHAIRMAN. I just want everybody to know that some of you, I think, have flown back and forth because your State legislatures are in session, so we really do appreciate your cooperation and look forward to its continuance.

Thank you very much.

Governor THOMPSON. Thank you.

The CHAIRMAN. The committee is in recess.

[Whereupon, at 12:53 p.m., the hearing was adjourned to reconvene on February 28, 1996.]

GOVERNORS' PROPOSAL ON WELFARE AND MEDICAID

(Administration's Views)

WEDNESDAY, FEBRUARY 28, 1996

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

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

Also present: Senators Chafee, Grassley, Hatch, Simpson, Moynihan, Baucus, Pryor, Rockefeller, Breaux, Conrad, Graham, and Moseley-Braun.

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

The CHAIRMAN. The committee will please come to order. It is my intention to proceed with today's hearing in the same manner as last Thursday's hearing with the Governors.

I know members will have plenty of questions for Secretary Shalala, whom we are pleased to have with us today. I want to allow as much time as possible to explore the details of the NGA proposal with her.

Therefore, I have a short statement, and then I would like to recognize Senator Moynihan for his opening statement, but would ask all other members to refrain from making statements so that we can get right to the questions.

At the outset, I want to stress this hearing is about the unanimous and bipartisan proposals on welfare and Medicaid reform, as forwarded by the Nation's Governors. I hope that we will keep the focus directly on the NGA proposal.

It has been 36 months since the President first told the Governors he would work with them to achieve welfare reform. Congress has presented welfare reform legislation to the President twice, the President has vetoed it twice, and the American people are still waiting for comprehensive and effective changes to the current welfare system.

So we should leave the past behind and move forward with fresh ideas and a renewed commitment to deliver the authentic welfare reform the American people need and expect.

Less than four weeks ago, the Republican and Democratic Governors joined together in an extraordinary bipartisan effort to cre-

ate a new proposal to restructure Medicaid and reform welfare. With this proposal, the Governors have given us an opportunity to determine if the differences which divide the Congress and the President can be bridged.

I hope that today's hearing will provide us with a clear understanding as to whether this is, indeed, possible. It's time to find out whether there is common ground. As the Governors indicated last week, the timing for legislation is critically important as State budget decisions are currently being made.

We need firm and definitive answers to tough questions. Yes, there are details to be worked out, but the NGA squarely presents the Congress and the President with basic, fundamental changes to the current welfare and Medicaid system which cannot be avoided.

Let us be direct and straightforward; we should not disguise principles as details. If we can agree on the major issues the details can be resolved, but let us not defer answers on these critical matters by simply raising more questions.

Last week, Governor Miller acknowledged to the committee that the NGA proposal is, indeed, a compromise and that the balance we struck is a delicate one. Governor Romer told the committee last week that their proposal to reform Medicaid is a true combination of a per capita cap and the block grant.

We need to find out today whether the administration will support the flexibility and the fundamental reforms the Governors seek. Let me now yield to my good friend and colleague, Senator Moynihan.

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

Senator MOYNIHAN. Mr. Chairman, I thank you for the spirit and the directness with which you have opened these hearings. I will speak but very briefly.

Sir, the Minority staff has developed from data provided by the Urban Institute and by the Department of Health and Human Services, the effects of the central provision of this law which would repeal Title IV–A of the Social Security Act and terminate welfare benefits after no more than 5 years.

This has not really been discussed. To the distress of those of us who look to the executive branch for data, we have seen no awareness of the consequences of this. This morning Secretary Shalala will announce that the administration supports a 5-year time limit. The administration is for this. I would like the administration officials in the front row to listen to what you are for.

There are now approximately nine million children on AFDC, and the number will rise to about 10 million and go up from there. In the year 2001, which will be the first year the 5-year time limit takes effect, we will drop 3,552,000 children from any Federal assistance. If this is wrong, I would like to hear the Secretary tell us so. Over the 5 years that follow, a total of nearly 5 million children will have been dropped.

Now, the question is, who are these children? We have calculated, very simply, half these children will be black, 49.3 percent. That is 2,414,000 children over the 5-year period. One-quarter will be white, 19.2 percent Hispanic.

To drop 2.4 million black children in our central cities and elsewhere from this life support system would be the most brutal act of social policy we have known since the Reconstruction. I see members of the subcabinet with their heads bowed; I do not blame them, I respect them.

That we might have contemplated such an act would have been unthinkable 2 years ago. I do believe we can go forward with time limits if provision is made for the children whose support expires, but we are not doing that. Until we do that, I think the action would be premature and potentially calamitous.

Thank you, Mr. Chairman. I have these numbers for the committee members.

[Charts referred to appear in the appendix.]

The CHAIRMAN. Well, thank you, Senator Moynihan. As you indicated, both the Governors' plan and the administration have come out for a 5-year limitation. Obviously, the purpose of these hearings is to determine what the effect of these changed policies will be, and that's one of the reasons we are, indeed, very pleased to have the Secretary of HHS here today.

Senator BAUCUS. Mr. Chairman.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Mr. Chairman, I know the Chairman would like to limit statements to the Chairman and Ranking Member, but I wonder if each of us could give very, very brief statements, and I mean brief. I do not mean to take the committee's time, as well as the Secretary's.

The CHAIRMAN. Well, my concern is that once we open it up they will never be brief.

Senator BAUCUS. Well, this Senator will be brief, I guarantee.

The CHAIRMAN. I would ask, if you want to make a statement, when it comes to your turn——

Senator BAUCUS. Well, Mr. Chairman, I really would appreciate if I could just make a statement, within a minute or two. It will not be more than that.

Senator CHAFEE. I will not be making a statement.

Senator CONRAD. I will not be making a statement.

Senator GRASSLEY. I will not be making a statement.

The CHAIRMAN. All right. Senator Baucus. He will be very brief, he says.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. I appreciate the Chairman's concern. Thank you very much, Mr. Chairman. I very much appreciate that.

First, I want to welcome the Secretary. I think you have done a great job, Madam Secretary, in various ways, not only generally but also in paying attention to some of the problems we have had in the State of Montana.

I know, Madam Secretary, you met recently with the Governor of our State, as Montana is trying to figure out, with the administration, a way to come up with a Medicaid mental health waiver proposal. I thank you, Madam Secretary, for your very great efforts in trying to accommodate Montana within the law. I very much appreciate that.

Mr. Chairman, I also might say that I think it is clear, and I think all Americans agree, we do need welfare reform. I think we should have it this year. The reason we have a welfare system is obviously to help people in a tough spot, get them back on their feet and back to work.

That is why we have welfare, to promote the values of work. That is why we are here today and trying to find a better way to promote those values; promote personal responsibility, promote self-sufficiency that we all share as Americans.

I believe our present system fails to do that. It is a tragedy. That is why we are here today, to try to find a way to make sure that the values we have as Americans—work ethic, responsibility, self-sufficiency—are better applied to people who are on welfare and most of whom want to get off it.

I share some of the concerns that the Senator from New York has, particularly with respect to children. As I look at the Governors' proposals—and I very much commend the Governors, Mr. Chairman, for making a good faith effort, it is a bipartisan effort—one main glaring deficiency I see is insufficient protection for children.

There is a $4 billion additional provision for kids, but it looks like the States can offset that, which means, on a net basis, children are not protected. I very much hope that that is a core focus of our effort here, to try to find a way to make sure our children are better protected than they now are in the Governors' proposal.

I thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baucus.

Secretary Shalala, at this time we would ask you to proceed with your statement. Then members will have 5 minutes for questions, and we will have as many rounds as seems appropriate.

Again, Secretary Shalala, it is always a pleasure to welcome you here and we look forward very much to your comments on this most important matter.

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

Secretary SHALALA. Thank you, Mr. Chairman, Senator Moynihan, and members of the committee. I want to thank you for giving me the opportunity to testify today about the National Governors' Association resolutions on Medicaid and welfare and the President's vision for reform in these areas.

I want to emphasize that the Governors' proposals are still in the resolution form; we do not have legislation from them. They are, to be fair to them, still in discussion about changes in their own proposals, strengthening them in many places.

They also have the comments from the administration and from many of you, and I know that they very much see their proposal as a work-in-progress, which gives us the opportunity to recommend changes to them and to all of you.

Throughout the years, this committee in particular has built a great tradition of bipartisan leadership on these issues and we look forward to working with you to reach bipartisan consensus on Medicaid and welfare reform legislation.

This hearing comes at a critical juncture in this country's history. Right now, from kitchen tables to the halls of Congress, we are engaged in an historic debate about the size, the scope, and the role of the Federal Government.

But this debate is about much more than deficits and devolution. At its heart, it is about who we are as Americans, what kind of legacy we want to leave for our children.

The Clinton Administration believes that we must balance the budget in 7 years and shift more responsibility to the States and local communities. But, as the President has said time and time again, we can balance the budget and find common ground without turning our backs on our values, on our families, and on our future.

We believe we can give the States the flexibility they need while still maintaining a strong Federal/State partnership built on a foundation of shared resources, accountability to the taxpayers, and national protections for our most vulnerable Americans.

That is the yardstick we must use to measure any Medicaid and welfare reforms, including the resolutions recently adopted by the National Governors' Association. Let me be very clear. While we applaud the NGA's ongoing contributions to this debate, we do believe that some of their proposals raise serious questions, questions about our ability to maintain national objectives and the Federal/State partnerships necessary to achieve them.

It is now up to this Congress and this administration to address those questions and build on the spirit of the Governors' efforts. It is time for all of us to work together to reach our mutual goals: flexibility for the States, incentives for AFDC recipients to move from welfare to work, the preservation of health insurance coverage for those who need it most, and protections for our most precious resource, our children.

Let me begin with Medicaid. The President has proposed a plan that strikes the right balance. It reforms Medicaid while preserving a real Federal guarantee of coverage and benefits. It maintains our historic Federal/State fiscal partnership and it gives the States unprecedented flexibility to meet the needs of their citizens.

We are pleased that the Governors appear to agree with one of the central ideas of our plan: all States must be given the resources they need to respond during times of unexpected change, for example, during economic downturns and population explosions that can increase Medicaid enrollment.

But, while we recognize that the NGA plan is still a work-in-progress, we are concerned that some of its central elements fail to reflect the priorities articulated in the President's Medicaid plan.

These are the need for a real, enforceable Federal guarantee of coverage to a Congressionally-defined benefit package, appropriate Federal and State financing, and quality standards, beneficiary protections, and accountability.

Let me briefly talk about these three components. On eligibility, we have concerns that the NGA plan partially repeals a bipartisan law signed by President Bush that will phase in Medicaid coverage for children between the ages of 13–18 whose families have incomes below the Federal poverty level.

We also have concerns because the NGA plan seems to discard the Federal standard for defining disability and replaces it with

separate State definitions. Although the Governors have retained the critical link between cash assistance and Medicaid eligibility, there are still some important questions that must be answered.

For the guarantee of coverage to be real for citizens all over this country, we also must have a Federal standard by which to judge benefits. Here we have concerns that the NGA resolution, as currently drafted, fails to provide that critical standard. It lists benefits that are guaranteed for the guaranteed populations only.

It originally granted complete flexibility on the amount, duration, and scope of benefits, although the Governors may have moved to a minimum standard in their most recent discussions. This is an example where their original paper is being changed while we are now speaking, and we believe in a direction that sets some minimum standards.

The NGA plan is silent, of course, on the current law standards of comparability and Statewideness of services among and within eligible groups for mandatory as well as optional services, thereby raising serious concerns about the potential for discrimination against certain groups, or actually certain people who have certain diseases.

To be real, a Federal guarantee must also be enforceable everywhere in this country. But for those individuals who assert that a State is violating Federal Medicaid laws, the NGA resolution would take away their Federal right of action and leave them with only one point of access to the Federal court: the opportunity to petition the U.S. Supreme Court.

Under their proposal we believe that Medicaid could be the sole Federal statute that denies its beneficiaries the possibility of Federal enforcement.

The second key issue is the financing contained in the NGA resolution. While offering a very constructive addition to the debate over Federal funding, the NGA proposal includes changes in the State share of financing that raised some concerns.

Under their proposal, minimum Federal contributions to the financing of Medicaid would increase from 50 percent to 60 percent. This could lead to significant increases in Federal spending, decreases in State contributions to Medicaid, and decreases in Medicaid funding for health care overall.

The NGA plan would once again permit States to have unconstrained use of provider tax and donation financing mechanisms, the very same mechanisms that Congress recently—and wisely—limited.

We do not know yet whether this plan will achieve the scoreable savings necessary to meet the President's and the Congress' goal of balancing the budget in seven years.

By repealing Title XIX and creating a new title for the Medicaid program we believe that the NGA resolution could seriously compromise the framework for quality standards for beneficiary and family financial protections, and for program accountability.

For example, it eliminates the Federal role in monitoring nursing home quality and thereby threatens to undermine the bipartisan standards that Congress enacted after a series of scandals to protect nursing home residents all over America.

Finally, the NGA resolution fails to clearly address protections that provide our families with the financial security that they need and deserve. While the Governors may have recently moved towards spousal impoverishment protections, they still have not addressed measures such as family responsibility protections.

For example, we do not know under their proposal whether the Governors can ask adult children of Medicaid recipients in nursing homes to pay part of the bill.

In conclusion, we believe that we must reform, not repeal, Medicaid. The NGA resolution has made significant contributions to our collective efforts to do just that.

We look forward to working with the Governors, members of Congress, and other interested parties to finish the job for the health of our citizens and the future of our country.

Now I would like to turn to welfare reform. As the President said in his State of the Union Address, although we have a long way to go we have already made progress. Welfare case loads have declined by 1.4 million since March of 1994, a decline of 10 percent.

A larger percentage of those still on welfare are engaged in work and related activities. Fewer children live in poverty, food stamp rolls have gone down, teenage pregnancy rates have gone down, and child support collections have gone up, as the administration continues to improve both the Federal and the State collection efforts.

Over the last 3 years, we have also worked hard to give 37 States the flexibility to design innovative welfare reform strategies that meet their unique needs. At the same time, the President has worked with Congress to dramatically expand the Earned Income Tax Credit to give working families a tax cut and to make work pay.

Yet, as the President said in January, it is time to take advantage of bipartisan consensus on time limits, on work requirements, and child support enforcement, and to enact national welfare reform legislation.

The President, as part of his balanced budget plan, has proposed a plan that does just that. In many areas, the NGA proposal reflects the President's approach. By adding $4 billion for child care, their proposal acknowledges what every welfare recipient will tell you. Single parents can only find and keep jobs if their children are safe.

In addition, we were pleased that the NGA proposal recognized the importance of giving States the ability to respond to unexpected changes in their population or downturns in their economy. We believe, however, that a provision should be added to the bill allowing States to draw down matching dollars during a national recession, even if the $2 billion in the contingency fund has been expended.

To qualify for the contingency fund, we believe that States must meet their full level of support, and, at the same time, we believe that the trigger mechanism should be improved to ensure greater responsiveness to the States' needs for additional resources.

I also want to note that the NGA proposal does make substantial improvements to the performance bonus provisions in the conference agreement by establishing a separate funding stream to

pay for bonuses rather than allowing States to reduce their maintenance of effort.

On food stamps, the NGA proposal makes two important improvements to H.R. 4, the conference bill. First, it does not impose a funding cap on the Food Stamp program, as the conference bill did. Second, the NGA proposal protects families with relatively high shelter costs, mostly families with children, by adopting the Senate's approach to the program's deductions from income.

Finally, the administration supports several provisions that the NGA adopted directly from the Senate-passed bill: a 20-percent caseload exemption from the time limit, a State option to implement a family cap, and requirements that teen mothers live at home and stay in school.

But, while the NGA proposal improves on the conference bill in a number of ways, the administration has serious concerns about several provisions. While we must give States flexibility to design programs that meet their specific needs, we can and must ensure accountability for our tax dollars and a safety net for our most vulnerable children.

The Federal/State match system, under current law, has always been the glue that holds this partnership together and was part of the welfare reform plan the administration proposed as part of its balanced budget plan.

In general, we have serious concerns that the NGA proposal weakens that historical Federal/State partnership. As I have already mentioned, the administration prefers the provision in the Senate bill which requires 80 percent maintenance of effort of the 1994 level, and a requirement for 100 percent maintenance of effort for access to a contingency fund.

We also oppose the NGA provision allowing a State to transfer up to 30 percent of its cash assistance block to other programs, such as Title XX, the Social Services Block Grant. We believe that the additional $4 billion in child care funds in the NGA plan should require both a State match and maintenance of the fiscal year 1994 level of State effort on child care.

The NGA proposal also contains several provisions which threaten the safety net for poor children. Unlike the Senate's bipartisan approach to child protection, the NGA proposal jeopardizes the essential safety net by allowing States to replace current entitlements for adoption, for foster care, for independent living, and family preservation with block grants.

The NGA proposal would also block grant important programs that prevent child abuse and neglect. We are pleased that, unlike the conference bill, the NGA proposal provides a basis for developing a requirement that States set forth and obligate themselves to follow specific objective criteria for administering their welfare programs so that both the States and the beneficiaries know the rules and are committed to playing by those rules.

Let me also say that the President has always favored, and his own bill contains, a voucher for children, for the children who would be left out if the time limits, indeed, come to pass for their families. This is both in the Daschle bill, as well as in the President's own bill. The President has firmly indicated that he supports a voucher to protect the children.

In conclusion, Mr. Chairman, let me restate the Administration's commitment to enact both a balanced budget, and Medicaid and welfare reform. As the President has said, budget cutting should not be wrapped in a cloak of reform. Let us pass needed Medicaid and welfare reforms, let us cut the deficit, but let us not mix up the two and pretend that one is the other.

We share the President's hope that, with the leadership of this committee, we can have bipartisan cooperation on the critical issues of Medicaid and welfare reform.

Again, I want to thank the committee for giving me the opportunity to testify, and I look forward to answering your questions.

The CHAIRMAN. Well, thank you, Secretary Shalala. As you know, many of us believe that the bipartisan group of Governors has really given some impetus to the hope that we can accomplish something in the area of welfare and Medicaid.

Last fall, President Clinton and administration officials indicated that the President would sign a welfare reform bill that resembled the bill that passed the Senate 87–12. On January 9th, the President vetoed a bill that actually provided more money in the TANF block grant and for child care. Now it is my understanding that there are reports that the President would not sign the Senate-passed bill.

What is the President's position on the bipartisan National Governors' Association proposal, do you think we can use this as a basis for legislation that would be signed by the President?

Secretary SHALALA. Well, we believe that on welfare and on Medicaid the Governors have made some very useful proposals. We believe that working with the Governors' proposals, as well as with the proposal, for example, that the Senate Finance Committee recommended, along with other ideas, that we can, in fact, draft a welfare bill that will be acceptable.

The President has laid out his principles for a welfare reform bill, some of which are incorporated in the NGA proposal and some of which are not. It must have serious work requirements. The Governors, in fact, have strengthened the work requirements from the conference bill.

It must protect children. Our concern is that the Governors' proposal does not include the kind of voucher protection for children once the time limits are reached—although it implicitly suggests that there would be a State option because it goes back to the conference bill.

It must contain proper accountability, parental responsibility, child support enforcement.

There are elements of these principles in both the National Governors' Association's proposal and in the bipartisan Senate bill that all of you worked so hard on, and we believe that a welfare bill can be crafted.

The CHAIRMAN. By a combination of a Senate bill and the——

Secretary SHALALA. I think a combination of that as well as the Daschle bill and the President's own proposals.

The CHAIRMAN. Well, let me point out that time is of the essence. We cannot go back to square one.

Secretary SHALALA. I understand that, Senator. But one of the things I would like to point out is that we do have legislation on

all of these elements. In fact, we have drafted legislation and we have worked through these issues with the committee.

If we go back to the principles that we all want to achieve—real work requirements, time limits, protections for children, including the kinds of protections that Senator Chafee has strongly supported for child welfare and adoption services, food stamps and the President has strong views, as you well know, on food stamps, the ultimate safety net for families—there is a welfare bill that can be crafted.

The CHAIRMAN. I do want to emphasize, what we seek to focus on today is the Governors' bipartisan proposal and whether or not we can move ahead expeditiously in getting legislation enacted into law that, of course, could be signed by the President.

Let me ask you this. Will the administration support block grants which end the individual entitlement?

Secretary SHALALA. The President has indicated that his preference is for conditional entitlement. Let me give you the reasons why. Our concern about block grants has to do with the protections that are built into the entitlements, both protections for children, but also protections against economic downturns.

You will see in the National Governors' Association recommendations that they build in some of those protections, because if there is an economic downturn in a State, if the State does not have an automatic ability to put people who have lost their jobs, who have no income onto their social safety net programs, the recession goes deeper and broader. That State also does not have the ability to tax its residents more during that economic downturn.

So I think the economic stabilizing effect of the entitlement is important, but that does not mean that we do not favor, at the same time, some time limits, as long as they include protections for children.

The CHAIRMAN. Well, I would like to point out that the NGA proposal, of course, is not a conditional entitlement. My basic question again is, would you support the block grant?

Secretary SHALALA. The NGA proposal, as it now stands, needs more protections for children. We need to make certain that if families hit the time limit and are not able to find jobs, that their children are protected. Our definition of the conditional entitlement includes automatic protections for children. The NGA proposal needs to have those pieces in it, along with some of the other things that we have indicated we are concerned about.

The CHAIRMAN. Going back to my basic question, I construe your answer as being, no, in its present form.

Secretary SHALALA. No, in its present form.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. Mr. Chairman, just to get our words straight, does the term "conditional entitlement," as used by the administration, not mean a 5-year entitlement, an entitlement for individuals that cuts off at 5 years?

Secretary SHALALA. But it has two other pieces to it, Senator.

Senator MOYNIHAN. First of all, do you mean by "conditional" it is entitlement up to 5 years?

Secretary SHALALA. We mean more than that, Senator.

Senator MOYNIHAN. All right.

Secretary SHALALA. We mean protections for children, we mean exemptions for people——

Senator MOYNIHAN. I give up.

Secretary SHALALA. Yes.

Senator MOYNIHAN. I asked a simple question; I should have known better.

What I would like to ask the Secretary is, does she agree that a 5-year time limit, in its first full year in effect, which would be, if enacted now, the year 2001, would result in 3,552,000 children losing their benefits?

Secretary SHALALA. If we are talking about the impact of the Governors' plan, which would obviously be phased in over time, I will agree with that number with two caveats. Number one, these numbers do not include the 20 percent exemption that the Governors——

Senator MOYNIHAN. If exercised.

Secretary SHALALA. If that is exercised. These numbers also assume that nothing happens, Senator. They assume that no more people are moved into the work rolls.

Senator MOYNIHAN. Right. Right.

Secretary SHALALA. So, to be fair to the Governors, this assumes that there will be no behavioral results of the welfare reform.

Senator MOYNIHAN. Right. We are grown-ups; we understand those two things. But a third of the children would lose their benefits. All right. Of those 3.5 million children, over a 5-year period it would come to almost 5 million children.

Would you agree that, of the 4,896,000 children, half would be black children?

Secretary SHALALA. I would not be surprised. Without going back over my dispute over the overall numbers, and that is to be fair to the Governors they really did not do some things.

Senator MOYNIHAN. We did not dispute.

Secretary SHALALA. All right.

Senator MOYNIHAN. We said that there are those qualifications which could apply.

Secretary SHALALA. All right. I would agree, because of what we know about African-American families, their educational levels, their lack of access to jobs, that more of the families affected would be African-American families.

Senator MOYNIHAN. Because they are the ones that tend more, disproportionately, to be on for longer periods.

Secretary SHALALA. Exactly. But the tragedy here, Senator, is that children in this country, under any assumptions, the fact that we would put up numbers that would suggest that millions of American children, if we do nothing, will end up spending at least a quarter of their lives on welfare. That is an American tragedy.

The idea of imposing a 5-year time limit without child protections obviously is not something that we support. But the fact that you can produce a number that indicates that large numbers of American children are going to be on welfare in this country, and are on welfare in this country, for 5 years or longer is an American tragedy, and that is the reason why we are discussing welfare reform today and anything else that we can do on the front end to begin to move these families into more productive lives.

Senator MOYNIHAN. Madam Secretary, we know this. This committee has worked on this for 30 years. That is why this committee unanimously reported the Family Support Act of 1988, which passed the Senate 96–1, which said welfare must not be a permanent condition, that there was individual responsibility to help get off, and a public responsibility to help the individual. It has been working very well, and you spoke very gallantly about the number of waivers that you have given to 35 States.

Secretary SHALALA. 37 States.

Senator MOYNIHAN. 37 States. Now, let us not get too picky about numbers. 37 States. Most States. It is working. Just when it begins to bear fruit, or seems to be beginning to produce knowledge, and the Manpower Demonstration Research Corp. says that is happening, we scrap it.

I think we are scrapping the lives of those children, too, half of whom would be black. We would never have dreamed of anything like this 3 years ago, and I do not understand how it has come to this today. Thank you.

Secretary SHALALA. Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. These words kind of stood out in your opening comments. You used the words, "our values," "our common vision," our "doing the right thing." It seems to me that the challenge that we are facing in this whole debate on welfare reform is that perhaps we do not have shared values, at least I would have to say not as you have outlined them.

I think, in terms of the history of this issue, Madam Secretary, the President was Governor for a long time, wanting to end welfare as we know it. We have 19 Democratic Governors that have come out in support of something that is unanimously accepted by the Governors' Association.

It just seems to me that there is an attitude being expressed, here at this meeting, in the press, and from the White House press stadium, that it is going to still be business as usual. That is what I kind of sense.

Now, I know that the administration's focus is upon "shared resources" and the "national protections for our most vulnerable." You cannot help but read those statements as the Federal Government still keeping a very heavy hand in this whole operation.

What we have tried to focus on in this Congress, even a lot of Democratic members of this Congress, are the American values of individual opportunity and responsibility, self-reliance, and ending welfare as we know it and replacing it with workfare.

Now, while the Senate has passed a bipartisan proposal by a vote of 87–12, the Governors have brought forward their bipartisan proposal.

I think we are having a very difficult time reaching an agreement with this administration. When you consider the political leadership among the Governors, including 19 Democratic Governors and a bipartisan bill that passed the Senate 87–12, and then to have the discussion we are having right now over legitimate policy differences, indicates that we simply do not have a common vision of America that you want us to believe we have. I do not think we are going to end welfare as we know it.

If we end up with a bill that you are suggesting we go along with, it is going to be welfare reform as we have done it in the past. But the bottom line of that is, welfare as we know it continues, business as usual, the status quo.

We cannot come to an agreement, because when it comes to the nitty-gritty policy differences we have, the administration and a majority of this Congress have a very different idea of what doing the right thing is. It is very fine to speak in broad terms about principles and goals; things sound very rosy when we do that.

But, when it comes down to putting specifics on paper, to carry out changes in policy, we find that the shared values that you talk about are not there.

I was disappointed to see the comments in the New York Times article from yesterday. I think that this article illustrates very clearly the conflict that we are talking about here at this meeting. The administration talks in nice platitudes about welfare reform, but when you get right down to it, it is kind of like Yogi Berra said, that "There is no there there." That is the bottom line.

So the only question I am going to have time to ask you is, however incomplete the Governors' proposals may be, one thing about it is clear, and that is, they want much greater freedom to organize and run their own welfare and Medicaid programs.

One thing seems clear about your comments today, and that is that the administration does not want to give that much latitude. I hope that that is a fair characterization. That is what I want you to comment on.

But let me just add here, there are numerous issues on which the Governors, Democrats as well as Republicans, are asking for greater freedom from Federal specification and oversight. On many, if not most, of those issues, your statement seems to indicate that the administration wants to retain substantially more Federal control than what the Governors want.

Secretary SHALALA. Senator, let me answer your question, first, on welfare and then on Medicaid, because I do not think it is accurate to characterize us as not having shared values. I share the values as expressed in the welfare waiver in Iowa.

I share the values of the people of Iowa, that the program ought to be individualized, that there ought to be protections for children, that people ought to be moved to work as quickly as possible. I would suggest to you the principles by which we are evaluating the Governors' plan are the principles as expressed in that waiver.

I would argue that we inherited the status quo. Half of the welfare recipients in this country, because of waivers in 37 States, are covered by new work standards, new imaginative programs designed by Governors as part of the partnership that we have been expressing.

So, on welfare it is hard to fault us when we have, in fact, in over 3 years achieved what could not be achieved in all of the previous years using the waiver process. We are working very closely with Governors who are genuinely excited. I would argue that what we want is flexibility for those Governors.

On Medicaid, again, using the waiver process, we have learned a lot about what the Governors want. The President's own plan gives them that flexibility, to get out of the waiver process for mov-

ing people to managed care, to get out of the waiver process for moving people to community and home-based care. The major proposals of the Governors are covered by these principles.

The issue for this committee is a fiscal one. That is, do you want to go back to the provider taxes as a way to make the match? Do you want to go back to proposals that would allow the Governors to pull their money out while substituting Federal money? Do we want to go back to the days in which every State has their own definition of disability? Do we really want to repeal the law that would cover adolescent children, who are relatively inexpensive to cover?

I think that we should look closely at the Governors' proposals to make sure this continues to be a partnership, a fiscal partnership—they put in their share, we put in our share—and we slow down the growth so that we can meet those balanced budget requirements and at the same time we protect vulnerable populations.

How are the people with disabilities in this country going to feel if every State has its own definition? What does it mean if, for the first time—and Senator Hatch is here—we have a Federal statute that gives people a right that cannot be enforced in the Federal courts?

I am simply raising questions, not about the values. I would not question the Governors' values; I have been working with them for 3 years. Those waivers that they are implementing very much reflect both the values of Republicans and Democrats, the values of this administration, and, I think, this committee.

Senator GRASSLEY. Nineteen Democrats. The Governors do not want waivers, they want control. That is what their whole proposal is.

The CHAIRMAN. I would point out that the 5 minutes are over.

Secretary SHALALA. In fact, our proposals eliminate waivers in almost all the cases that the Governors have put forward.

The CHAIRMAN. The Chair wants to try to keep as close to 5 minutes as possible, so everybody has a fair chance.

Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. Mr. Chairman, I would just comment that I think this committee, with jurisdiction on both welfare and Medicare and Medicaid programs, has a unique opportunity to get the job done.

I would very much hope that the Chairman would have an opportunity to schedule a mark-up on these recommendations and whatever bill we have before someone makes an effort to just dump a welfare bill onto a debt ceiling, for instance, without us having the input, and writing a piece of legislation that gets the job done. So I would very much hope that, at some point, we would have an opportunity as a committee to function and to push forward a real bill.

Let me just say, Madam Secretary, I support time limits. I think that——

Senator MOYNIHAN. If I could say, the Chairman has indicated that he wishes this to be a full committee activity, and a bipartisan one, as it was not previously. I think we all appreciate that.

Senator BREAUX. I am glad to have that. I am concerned that they are talking about a debt ceiling that is going to be due March the 15th, or maybe right after that.

Senator MOYNIHAN. Over there.

Senator BREAUX. Over there. That other body over there.

The second point, Madam Secretary, is I support time limits. I think any real welfare reform bill has to include time limits. Hopefully, if welfare reform works there will be fewer children on welfare after 5 years. There will be fewer children on welfare after 5 years because their parents have gotten a job.

If the parents, after 5 years, have not gotten a job, we have an obligation to protect the children. We do it by keeping them eligible for food stamps, we do it by keeping them eligible for health care under Medicaid, and I think we ought to also take care of them by making them eligible for vouchers, which is something that would take care of that problem.

Can you comment on my comment as to whether that would, in fact, accomplish the type of welfare reform program that the administration could support, with a time limit?

Secretary SHALALA. It is exactly what the President has talked about and what is included in his own bill and, of course, was included in the Daschle bill, too. I would only add that we want to make sure that child protection services are available for these children. We would want to be extremely careful about that in addition to the things that you have listed.

Senator BREAUX. We also have to watch the purse. I mean, the Governors came in and said, all right, we want $4 billion more on child care. That sounds fine, but they do not want to have it require a State match. I take it that that is not acceptable.

Secretary SHALALA. It is not acceptable. I think we have to be very careful. One of the things the MDRC people said to me, Senator Breaux and Senator Moynihan, is that to have a successful welfare reform program, the States have to have a stake in it. Their own money in it is important as well as the flexibility that we are talking about. So, making sure we continue that stake in the programs is extremely important.

I could not be more sympathetic to their budget problems, I have to admit. As someone who ran a public institution, every year I had to cut my budget because either Medicaid or some other social safety net program had been mis-estimated. So I could not be more sympathetic to the fiscal discipline we need here. But, at the same time, the States need to keep their match in the program.

Senator BREAUX. Well, the only organization that has worse budgetary problems than the States is us. I am for the $4 billion in extra money for child care; I think that is absolutely essential. But they have to participate, too.

Now, they have also included a $2 billion contingency fund, which I think is a good idea for the States that fall under difficult times. But I take it they do support a match requirement and a maintenance of effort requirement in that level.

Let me talk about the maintenance of effort. We are talking about 75–80 percent. I mean, there is not a lot of difference here. If there were an 80 percent maintenance of effort requirement, can

the administration live with that? I mean, does it have to be 80, or could it be 75; what are we talking about here.

Secretary SHALALA. I think that we have supported 80 percent, but as part of the discussions, obviously, we would want to work with the committee. We have been supportive of the proposal that the States ought to be maintaining their effort at the same time before they tap into the contingency fund.

Senator BREAUX. At 100 percent.

Secretary SHALALA. At 100 percent.

Senator BREAUX. I think they said they are willing to do that.

Secretary SHALALA. Yes.

Senator BREAUX. A 100 percent maintenance of effort for the $2 billion contingency fund.

Secretary SHALALA. Exactly.

Senator BREAUX. Another question I have, is on the definition of disability and the enforcement provisions. I felt, and I think you made a good point, that whether they did it on a State level or a Federal level did not make a lot of difference.

I, quite frankly, thought that people in my State may do better in a State court than they would in the Federal court, and the State could still enforce it. But your concern is what, that you would have 50 different standards, perhaps?

Secretary SHALALA. You would have 50 different standards. In addition, this really is a law of the land. We ought to have some fundamental laws of the land to protect children, to protect vulnerable populations.

To have a Federal statute that ensures an individual right and not have it enforced by the Federal courts would be unusual, to say the least. This would be the only Federal statute, as far as I know, that would not be enforced in the Federal courts. The Federal courts have a way, as you move up to the Federal system, of making it a law of the land. We would support that.

Senator BREAUX. I would just conclude by congratulating you on working with this. I mean, I think the Governors do not have a perfect package, neither do those of us who are trying to write it in Congress, but we all need to work together. It is not just a Federal solution, it is not just a State solution. I think it is an American solution that we all need to be involved in.

Secretary SHALALA. Exactly.

The CHAIRMAN. Senator Chafee is next, to be followed by Senator Conrad.

Senator CHAFEE. Thank you, Mr. Chairman.

Madam Secretary, the National Governors Association has proposed a mandatory coverage of individuals with disabilities, but the definition of disability is left to each State. I expressed concern about this when the Governors testified.

I also want to say here it was a very, very impressive group of Governors, including your former boss, Governor Thompson. I think all of us came away with the feeling that those Governors were an outstanding group and were very, very good Governors.

But, nonetheless, on this particular issue I had some trouble, but they assured me that the Secretary of the HHS would have the ability to deny approval of a plan if the definition was inadequate. But I had difficulty on that. On what grounds could the Secretary

deny approval if the law gave the States the ability to define the population?

Secretary SHALALA. Senator, we have also raised with the Governors the issue of, the standards by which the Secretary of HHS would approve the definition.

My own sense from talking to the Governors—and I think that they really have provided a useful step and they have worked very hard—is that they have some concerns about the definition of disability. Some of that has been discussed here as part of welfare and SSI reforms.

In fact, this committee has addressed some of those issues. The new definition of SSI, for instance, would address the specific problems that the Governors have mentioned. We prefer a national definition of disability.

This Secretary of HHS, no matter what the criteria are, is not enthusiastic about approving 50 different definitions of disability. I think in this case we should go back to the Governors and find out their specific concerns.

I believe that some of them are addressed in the SSI welfare proposal that the Senate, and this committee in particular, have dealt with. We ought to address them directly as opposed to what will be, I believe, a nightmare for them and a nightmare for whoever is lucky enough to be sitting in the HHS seat at the time.

Senator CHAFEE. You touched on the phase-in of the children from 13 up to 18, which is the current law. By the way, they are at 100 percent of poverty or less, so it is not exactly an affluent group in our society.

Do you know how many States currently cover that population that have gone up to the 18, under the optional?

Secretary SHALALA. Twenty.

Senator CHAFEE. Twenty out of the 50. You also mention in your testimony that this is a relatively inexpensive group to cover. Could you just touch on that a little bit.

Secretary SHALALA. Children are quite healthy and relatively inexpensive to cover, even under the benefit package that is mandated under Medicaid. It also is a group for which many of us, and many people in this room, have spent time worrying about issues like teenage pregnancy.

The Carnegie Commission recently came out with a major study of adolescents and the centerpiece of that was our need to deal with adolescent health issues. To now back away and literally reduce the number of children Congress had planned to cover, it seems to me, would be very unfortunate. This is an at-risk group; low-income, poor adolescents are a high-risk group. We ought to cover them. Of all the priorities we have as we are worrying about finances here, it seems to me this is relatively easy to do.

Senator CHAFEE. The National Governors have proposed—and you touched on this in your testimony—limiting the current restrictions that we enacted on provider taxes and on voluntary contributions. Now, I always felt these taxes were a scam from the word go.

So, we put restrictions on it, modest restrictions. I think this was in 1991. In your opinion, would the repeal of these allow the States to significantly reduce their Medicaid payments?

Secretary SHALALA. It would, because what they would be able to do is use these provider taxes as a substitute for their own money. This committee did describe it in a variety of colorful terms.

But the real impact is not only the match requirement which we believe very strongly is part of this partnership, but it drives up the cost of Medicaid. Once this committee and the Congress tightened up, we drove down the cost. At one point I think it went up to 29 percent.

So, it has huge fiscal implications if we go back to provider taxes and huge implications for the ability to shift out real State dollars from the match.

Senator CHAFEE. My time is up.

Secretary SHALALA. If anyone is considering this, our Inspector General has asked me to say she very much would like to come and testify specifically on this subject.

Senator CHAFEE. Thank you.

The CHAIRMAN. Senator Conrad is next, to be followed by Senator Simpson and Senator Rockefeller.

Senator CONRAD. Thank you, Mr. Chairman, and thank you Secretary Shalala. I want to say I think you are doing an outstanding job as well. I have very much appreciated all the time, effort, and energy that you have put into analyzing and proposing how we might deal with these difficult problems. I think you have just done a superb job.

Secretary SHALALA. Thank you very much, Senator.

Senator CONRAD. I also want to commend the Governors for their efforts, because a number of us have worked closely with them. And, while I have serious doubts about some elements of their proposal, I want to acknowledge the effort that they have made.

As soon as I say that, I want to be clear that the more I examine the specifics of what they have proposed the more the block grants look like blank checks to me. The more I see, the more concerned I am that we are in the position of raising the money and they are in a position of spending it.

I am not terribly surprised that the Governors are unanimously in support of that; that is a pretty good deal. I really question the principle. I question it very, very seriously. Separating the responsibility for raising money and the responsibility for spending it seems to me just a bad principle, right at the heart of these proposals.

It seems to me, if the Governors want complete control on how the money is spent, then they ought to have the responsibility for raising it. If we are going to have the responsibility for raising it, then we have got an obligation to the taxpayers that we tax to have some say in how it is spent. That, to me, is a first principle.

Now, in line with those questions, as I examine these proposals, I see significant opportunity for State gaming of the system in order to tap into the Federal treasury to maximize what they get from the Federal Government in order to offset financial demands that are being made on them.

I would ask you specifically whether or not you see ample opportunities to raid the Federal treasury with respect to these proposals. Let me be specific. It appears that the States would have complete flexibility to redefine disabled to cover populations for which

States have historically been 100 percent financially responsible. Do you see that opportunity?

Secretary SHALALA. Well, it certainly could be, combined with the ability to define what categories of people are going to be served. For example, as one Governor came in to ask me permission to do, States could shift their entire mental health expenditures to the Medicaid program without having the basic benefit package. There certainly would be the opportunity for that without proper controls.

Senator CONRAD. Well, that is precisely one of the examples that I have cited in a letter to the Chairman and in a transmittal letter to the Governors who are here. That seems to me a serious opportunity for gaming and tapping into the Federal treasury and not meeting their own obligations.

A second would be, in any year in which the Federal cap threatens to bite and leave States without Federal matching funds for additional services, States could use the complete flexibility on amount, duration, and scope to ensure that beneficiaries receive virtually no services, while aggressively increasing enrollment to tap into the umbrella fund. Do you see that potential?

Secretary SHALALA. Again, as I mentioned, once you have control over who is eligible and what they get, then you can thinly spread your money as a way of attracting more Federal money. We would have concerns about that.

To be fair, while these are all technically possible, we should not ascribe motivation to any individual Governor. It is just that we are opening up a Pandora's Box with this and we want to be careful that we have some standards.

Senator Conrad, again, as someone who has been on the other end, I want to make sure that, along with you, we strike the proper balance. We have overregulated these programs. These Governors are ready to take more responsibility.

We have learned some things out there. The waivers have taught us some things about what the Governors ought to go ahead and do without coming to Washington. So finding the balance is what you and I are talking about.

Senator CONRAD. That is precisely right.

Let me go to another question. I support strongly increased State flexibility. I think many of the points the Governors are making are absolutely correct. But I have serious concerns about the lack of accountability under the Cash Assistance Block Grant.

As you know, current law requires States to protect program operations from political influence and corruption. There are no such provisions to protect against these abuses in their proposal that is before us. What kinds of checks and balances would there be in the Governors' proposal to ensure fair and effective use of Federal tax dollars, from your vantage point?

Secretary SHALALA. We would have to go back through. On Medicaid, for example, because we are not working off of Title XIX, all of those accountability provisions would not necessarily be part of the bill. So, we need to go back.

If the committee intends to write a new title, those accountability protections—on welfare they have to do with personnel and with contracting; on Medicaid the strong fraud provisions—must be put back in. That is one of the reasons I made a point in my written

testimony about working off of Title XIX, because those accountability provisions are in there.

Senator CONRAD. Well, let me just conclude if I can by saying, I think if we were working off the Senate version rather than off the conference version, some of these things would be addressed. I wish we were dealing with what we had done here in the Senate, because a lot of these things would be addressed in that circumstance.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Senator Conrad, I thoroughly agree with you. I think that one of the great stumbling blocks of this whole operation is that we did not work from the Senate bill that we passed, but rather the version that came with the conference report.

Much has been made, Madam Secretary, about the Governors' bipartisan agreement on their Medicaid report. Some of us were here when they testified, and they were, indeed, an outstanding group of Governors.

But let us be very clear about two things. Number one, this entire proposal is six pages. I mean, this does not even constitute the preamble of the simplest piece of legislation that the Congress would have to produce. So it is purely a thumbprint.

Second, as they were testifying they were disagreeing with each other. For example, Governor Romer would suggest something and one of the Republican Governors would say, "yes, I think we have to go back and look at that."

I have been a Governor; I know exactly how those NGA things work. Somebody says we have a bipartisan agreement because the main Republican and the main Democrat agreed, so they vote it right through, and everybody says it is unanimous. Well, it is not unanimous. It is not unanimous at all. Most of them have not looked at it. That, of course, never happens in the Congress. [Laughter.]

But they have one thing that you refer to in your statement on Medicaid, which I think is absolutely shocking, where they specifically say, "The following benefits remain guaranteed for the guaranteed populations only."

They list a magnificent set of services available, and then end that paragraph by saying, "States have complete flexibility in defining amount, duration, and scope of services." In other words, wiping out everything which they have written before.

So, let us be very clear on this. This is a good faith effort on the part of the Governors. It does not represent any detail whatsoever. The devil is in the details, and there is a lot of work to be done as far as they are concerned.

Now, I have a couple of questions. One, has to do with the fact that, thanks to people like Senator Chafee and others, we have had a long tradition here in the Senate of supporting foster care entitlement and maintaining current law on child welfare services. This appears to be blown away by the NGA. They have this so-called optional block grant for welfare programs, and then a mandatory block grant for all other welfare services and protective services.

We are talking about abused and neglected children. These are the most fragile in our society. For example, you mentioned demo-

graphics, population changes, geography. What would happen if you could come to August in a certain year and, because there had been a recession or something else, the block grant money would have run out?

Is it not entirely possible, in that there is an absolute limit under the Governors' plan, that abused and neglected children would be unprotected? Is that not correct?

Secretary SHALALA. Under a block grant there certainly is a possibility. Senator, I should acknowledge your own leadership on child protection services, along with Senator Chafee's. I know you have written to the President recently about this. It is very important that we retain these protections. And, as you know, the States do not have a distinguished record on delivering these services. There are a number of States that are under court order now.

Senator ROCKEFELLER. Twenty-two States under court order for not delivering services.

Secretary SHALALA. And many of these services are already underfunded. Of all of the children in this country, these are the ones that need the most time and investment and we must be very careful about pulling both resources or putting them or the people who provide them with services at any kind of risk.

Senator ROCKEFELLER. Thank you. The second question relates to something that I started in West Virginia back in 1982, and it was called CWEP. I think it still is. Thanks to Senator Moynihan, it remained in the 1980 Family Support Act.

But there is a problem. Just as employers are now contracting out and hiring temporary employees so as to not be able to pay benefits, there is a possibility—and a fear, therefore, on my part—that local communities could displace existing workers who have benefits and who have coverage in order to give community service work to people addressed under welfare reform. I think that would be wrong and I think that would be unfair. I would like to hear the Secretary's opinion on that.

Secretary SHALALA. We believe that welfare reform should emphasize work and job opportunities, but not at the expense of other workers. We do not believe that the bill that the President vetoed adequately protected existing jobs and working people. But there has to be a balance between putting welfare recipients to work and protecting other workers, and it is possible to build some of this into any kind of bill. We ought to be very careful about this.

Senator ROCKEFELLER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you very much, Mr. Chairman, and thank you Madam Secretary, for your excellent presentation. As a former Governor, I share the feeling that the Governors have performed a valuable service in terms of providing an architecture upon which we might be able to construct a bipartisan set of reforms in both Medicaid and welfare, and I believe they deserve considerable credit for accomplishing that.

I would like to ask a series of questions that relate to a concern of mine. Today, approximately one-third of Medicaid funds and a growing percentage of Medicaid funds is being spent on the elderly, as they live longer, as they require more intensive services.

A concern I have is that, before we commence reforming Medicaid, which is a significant part of the health care service financing for millions of older Americans, that we ought to have a concept of what we think is appropriate national policy for older Americans for the next generation.

I wonder if you could share with us what your vision of that policy is, and then comment on the Medicaid proposals as to the extent to which they are consistent with that vision or what modifications you would recommend to make it consistent.

Secretary SHALALA. In this case we are talking about Medicaid, but to talk about health policy in relationship to older Americans you also have to integrate the Medicare program at the same time. This country has made an historic commitment to senior citizens.

In making that commitment, we did not anticipate—and we ought to be honest about this—that we would be as successful in people living as long as they are living. One of the reasons we are in some financial trouble is because people are living longer.

I believe that the administration, working with the Governors on the Medicaid program in particular, is beginning to outline a vision shared by many leaders of Congress, including yourself and those who are represented here, that suggests, for instance, a much more flexible approach to the provision of long-term care services to help people stay in their homes longer.

The Governors very much want, and we believe deserve, the flexibility to move more of the populations to home and community-based care as opposed to simply using nursing homes or hospital care of some kind. That kind of flexibility will be extremely important in the future.

At the same time, we should anticipate that the populations, as they live longer, will also become poorer. So we have to be extremely careful over issues like spousal impoverishment, or tapping into the incomes of the adult children of senior citizens.

I am very concerned that the NGA proposal is silent on the other family members because often by the time someone gets to the point where they need home care or nursing homes, their adult children are themselves in their 1960's.

So we want to be careful about the financing of the system, at the same time making sure that we have a much more expanded view of long-term care and flexible approaches to long-term care, along with the kind of fiscal restraints, some of which will come out of our experience in managed care.

As you well know, though Florida has had a mixed history with this, we need a lot more experience with managed care or case management of senior citizens' care. We are beginning to get experience in Medicare. We have very high numbers of people in Medicaid in managed care.

As the industry itself becomes more mature and learns how to handle more at-risk populations, I think it will help all of us, not simply to save money—I am not sure how much money we are going to save in the long run—but for more quality care within the kind of growth rates that we want to live.

Senator GRAHAM. If I could follow up on several of the points that you have just made, Madam Secretary. There is a certain irony here. If we were holding this hearing 15 years ago when

President Reagan was in office, the President's proposal would be not for block grants for Medicaid to the States, but rather a federalization of Medicaid.

That was part of President Reagan's new Federalism, was that the Federal Government would take over Medicaid, the States would assume greater responsibility for transportation and some other areas. One of the reasons for that proposal was the need to blend Medicare—which is, of course, a totally Federal program today—and Medicaid more closely.

I would be interested in your further thoughts as to how, under the proposal that is currently before us, we could move towards that closer relationship between Medicare and Medicaid. It seems to me that, in fact, we may be making it more difficult to integrate those systems. So maybe I can ask if you can respond to that question at a later time.

Secretary SHALALA. I would be happy to. It requires a very thoughtful answer, and I would be happy to write to you and come by to talk about that issue.

Senator GRAHAM. If I could, I would like to ask one last question which relates to the issue of flexibility. I applaud the fact that, under your leadership, there has been much greater willingness to grant waivers to States. But what would be the reaction of the department now if States even became more aggressive with their waiver request?

For instance, moving towards managed care for elders, allowing States to back off certain restraints such as the Boren Amendment, being more flexible in terms of standards to allow greater use of non-institutional-based services, beginning to bridge some of the divisions between social services and medical services which are important for elderly.

How would you react to those kinds of more aggressive waiver requests for States as at least an interim alternative to block grants?

Secretary SHALALA. Senator, we believe that within the context of the current entitlement that the Congress could repeal the Boren Amendment, give the States the flexibility of moving populations to managed care without a waiver request and using more optional kinds of long-term care—community-based care, home care—without coming to us for waivers.

The fact is, the States are getting very aggressive and overwhelming us with waivers in these areas. We have identified those areas where they want to move. We have had considerable experience in this area and we think that the Congress, as part of a Medicaid reform, could actually give the States permission to do that without coming to the department for waivers. That includes the repeal of the Boren Amendment.

Senator GRAHAM. But you would think it would take Congressional action. You do not have the current authority to meet those.

Secretary SHALALA. I would have to grant a blanket waiver. Remember, and I need to remind myself, my waiver authority is for demonstrations, which require detailed evaluations and a more limited authority. We believe and we recommend that the Congress now move to institutionalize that to reduce the need for the States to come to the department.

Senator GRAHAM. All right. Thank you.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman. Thank you, Madam Secretary, for your very fine presentation this morning. I want to ask a question about nursing home standards and the Governors' recommendations, if I might. What would the Governors propose as to regulations on the Federal level; do they propose to just do away with the regulations on the Federal level? How do you interpret their proposal?

Secretary SHALALA. Although it seems that they retain the current law standards and protections, they actually eliminate the Federal role in assuring quality. And, as you well know, the States now administer the standards.

What we retain is the enforcement and the oversight authority. We would be reluctant to give that up, given our recent experience.

Senator, it would not surprise you. If you and this committee came with me to the Health Care Financing Administration office in Baltimore, I will show you recent experience of what those Federal standards are now finding State by State which would make the hair stand up on the back of your head. It is shocking what is still going on, in terms of nursing homes around the country. We need to pay attention.

I think the State administration of these standards, this partnership has worked very well. We often have State officials that are in the office that are helping us to implement these standards and we have a good working relationship. They need the resources to do it, and we ought to continue that relationship.

Senator PRYOR. Madam Secretary, if the Governors' recommendations took effect, and if the Department of HHS determined that the State was not taking appropriate action against a nursing home, would it be your interpretation that HHS could take any action, or would HHS be stripped of any authority to move against that home or to move against that State, do you know?

Secretary SHALALA. We would have no authority.

Senator PRYOR. You would be stripped of all authority under those circumstances.

Secretary SHALALA. In fact, throughout the bill we are stripped of authority for any kind of enforcement of accountability, and that would be a concern.

Senator PRYOR. Madam Secretary, thank you very much. I am going to yield back the balance of my time.

The CHAIRMAN. Would the Secretary not have authority under those circumstances to cut off funds?

Secretary SHALALA. No.

The CHAIRMAN. If you are in violation of the State plan.

SECRETARY SHALALA. I could probably cut off total funds to the State, but I would have no targeted authority. This is a case where it is working, where the Federal/State partnership is working. The Federal standards put in place by Congress, because of nursing home abuses, are now in place. Even the industry, which is working closely with us, would recognize that the standards are working.

The CHAIRMAN. Next, is Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much. First, to the Secretary, I am delighted that you are here today. I only got to hear the tail-end of your actual testimony; I was in a Banking Committee at the White Water hearings, to my good fortune.

I wanted to focus in on a couple of issues coming out of your work with the Governors and their recommendation. In the first instance, I want to commend you. I mean, I think everybody is working hard to try to address these issues, but certainly I do not think there is any question in anybody's mind but that welfare as we know it is no more and no less than our Nation's approach to the issue of poverty.

Certainly the bottom line issue is child poverty. I think the whole issue of whether or not they are deservingly poor gets to be kind of irrelevant when you are 5, or 6 or 7 years old. The fact of the matter is, children do not have much control over the circumstances of their existence. They have to depend on us grown-ups to take care of them. I have been very concerned about the time limit effect in the Governors' plan.

Senator Moynihan came up with some statistics that really troubled me greatly. In my State of Illinois, some two-thirds of our welfare case load is comprised of children. These are people who cannot work, these are people who are dependent on grown-ups to take care of them.

Yet the work that Senator Moynihan has produced indicates that, assuming that other factors remain the same, by the year 2005 almost 5 million children will be left with nothing, no subsistence.

We could call it welfare, we could call it charity, we could call it Fred for that matter, but the fact is, our response to poverty as a national community will no longer exist for almost 5 million children. I would, in the first instance, ask if you agree with this number and the conclusion there, and if so, to have your response to it.

Secretary SHALALA. Senator, I think I made two points about the numbers. First, that they do not build in the Governors' 20-percent exemption for hardship cases. That is, the Governors have asked for a 20-percent exemption for hardship cases so that they can exempt certain populations that clearly cannot work.

Second, they assume that the Governors and the States are unsuccessful in increasing the number of people that move to work. But I do not dispute the fact that, if we do not build in protections for those who cannot work, at the end of the 5-year period there will be, as there is now within the system, too many people who will be pushed into terrible poverty.

I would argue that, within the current system, there are too many people that are on welfare for too long. But I think my basic point is, welfare reform must protect those who cannot work, who are 5 years old, or elderly, or are terribly disabled. It must provide incentives for those who can work. Those ought to be the goals of welfare reform.

There is no dispute in this administration that welfare reform, whatever we do, must firmly protect those who cannot work within the time limits, after the time limits. Those protections must be built in to welfare reform.

Senator MOSELEY-BRAUN. I am particularly concerned, Madam Secretary, even assuming 20 percent, that is still almost 3 million kids with nothing. But another set of figures, and this is the second chart that Senator Moynihan's staff produced, and I am delighted that they did, goes to the issue of disparate impact and whether or not there is a civil rights cause of action involved here when you consider that, of those children—again, we are not talking about grown-ups, these are children—almost 50 percent of the children impacted will be African-American, 25 percent white, 19 percent Hispanic.

Now, clearly, there is a disparate impact, a negative impact on African-Americans specifically by virtue of the time limit that is provided. I would like your response to that.

Secretary SHALALA. I indicated, Senator, that I was not surprised because of the number of African-Americans who had lower education levels, who were located in areas where there was less job availability, who did not have access to education and training. I think the point here is that it would have a disparate impact on minorities, in particular, and that we ought to be concerned about.

But the fundamental principle here must be that the children must be protected.

Senator MOSELEY-BRAUN. Well, these are children we are talking about.

Secretary SHALALA. Yes.

Senator MOSELEY-BRAUN. All right.

Secretary SHALALA. Five-year time limits, under the Governors' proposal, which does not have built into it vouchers, food stamp guarantees, child protection guarantees, ought not to be acceptable to us.

What we must do is separate those who can work from those who cannot, protect those who cannot, and make sure we have every incentive and every early investment so that they do get into the work force so that they can take care of their children.

The best protection for American children is not Federal laws, but parents who want them and can take care of them.

Senator MOSELEY-BRAUN. Right.

Secretary SHALALA. And we have to do everything we can to support their parents so that they can take care of them.

Senator MOSELEY-BRAUN. No one disagrees. Mr. Chairman, I have one other follow-up question, if you do not mind.

Madam Secretary, again, in that vein, most of these children, again, according to statistics, live in families headed up by single women.

In a study that I would like to call your attention Welfare Reform and the Labor Market Reality, shows that, instead of people not looking to work, in Illinois, there are, on average, four job seekers for every entry-level job in the City of Chicago; that is six job seekers for every entry-level job. In southern Illinois, nine job seekers for every one job.

So the point is, under the plans that it sounds like you are moving toward endorsing, there is neither the ability to combine work with assistance, nor are there vouchers to address the whole employment issue. That is a real concern.

I would point out, I had amendments at both the committee and at the floor level for vouchers to provide that safety net, although the Administration supported my amendment, both of those amendments went down.

So, I would ask your response with regard to the fact that the realities in terms of employment are that these single women who have these children, there are no jobs out there for them.

Secretary SHALALA. Senator, I would make two points on that. First, going back to the voucher, in both the President's bill and the Daschle bill, we supported vouchers, the ultimate safety net, along with food stamps and the other supportive programs. But let me make a point about the welfare population. Large numbers of welfare recipients who enter the welfare rolls today will find jobs.

The point about welfare reform is to help them stay in the work force. We know, for example, from other studies that there are a million people that would leave welfare tomorrow if they could get Medicaid. Their problem is health care.

They may have a child with a chronic illness and they cannot find a job that has health care that goes along with that job. The Governors would like some flexibility in this area so they can build in some individual situations.

Second, the Earned Income Tax Credit. This President's and this Congress' substantial investment in the Earned Income Tax Credit helps people to stay in the work force because it lifts their incomes, if they have children, above the poverty line. The combination of that, plus the Governors, to their credit, have asked for substantial increases in child care.

So, for a very high percentage of what we currently call the welfare population, 70 percent of whom will move off of welfare in a 2-year period, and a larger percentage after that, if child care is in place, if the Earned Income Tax Credit is in place, if there is some access to health care of some kind, particularly for those who have children who have chronic illnesses, we can stabilize them. And obviously we feel strongly about the minimum wage going along with that, and we can stabilize them in the work force.

But, in addition to that, we must make sure as we move to a transitional program which has time limits, that we protect children.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Thank you, Mr. Chairman. Donna, how are you?

Secretary SHALALA. Just fine, sir.

Senator SIMPSON. You and I have trod the boards together at the Arena Stage.

Secretary SHALALA. Yes, sir. No one here understands that.

Senator SIMPSON. No, they do not. They do not understand that we were not even getting paid for it; that was the worst part of it, and that we could not have kept it if we had been paid for it. But we do benefit performances on behalf of the Arena Stage.

Secretary SHALALA. Bipartisan.

Senator SIMPSON. Bipartisan, yes. I mean, when I sing a duet with Nina Totenberg, you know it is bipartisan. [Laughter.]

But I enjoy you very much, and you have been very helpful and always very accessible to me in any questions I have had.

It is a tough one. Senator Moynihan, who is probably the most respected person in this area over the long-term on welfare reform, I think would admit with all of us that the present system is a failure.

So in the Senate, by a bipartisan vote of 87–12, we passed something which was, I think, quite a good step, in any event. But we know, I think, all of us, honestly, that the present system is not working. It has been in effect and the money has gone out, and the statistics are still grotesque.

We can continue to talk about the children, and the poor, and the sick, and that then freezes us in place. I do not know of anybody in the Senate that really is evil about the poor and the children, but you would think that.

That is the brush that is used now, that somehow those who are interested in slowing the growth of these unsustainable programs are evil, hate children, want to do something with children, in cafeterias with the school lunch, doing things to senior citizens which are unconscionable. And we talk about jobs. I still say, the best human right is a job.

So you hear about human rights all day long. Nobody talks about the population policies of the United States; there are none. How are you going to provide a job when the population of the United States doubles in the next 60 years? There will not be enough jobs. Then who will be suffering?

The Vice President is on that tack with his population issues, and I admire that. I have worked on those with him. But, again, my curse is that I was on the Entitlements Commission with Senator Carol Moseley-Braun and Senator Moynihan. These programs are unsustainable.

I am not trying to be clever when I come back to the fact that you, as a trustee of the Social Security program, you, as a member of the President's Cabinet, know that Social Security will go broke in the year 2029 and will begin its decline in 2012.

When Senator Moynihan and company saved it back in the 1980's—this is a broken record, but obviously the people cannot hear; they are hopeless—we saved the system until the year 2063. That is what he did. That is what Pat did, and company. Every year we get a report——

Senator MOYNIHAN. In company with Bob Dole.

Senator SIMPSON. In company with Bob Dole and others, the Blue Ribbon Group. We were told a year ago it would last until 2036, and then in 1 year they moved it up to 2029. You know that, and I know that. So what good does it do to talk about these things in the present?

The President, I thought, did a great job when he listed generational accounting in his first budget. In the second budget, it was completely eliminated. The reason it was eliminated is because it was too hot politically.

So we are all sitting here. We all know exactly what has happened. Medicare will go broke in the year 2002. If this evil Republican scheme should work, Medicare will then not go broke in 2002, it will go broke in 2010.

What have we done for the poor, the young, and people like that in that process? How can we avoid the fact that one out of eight

are over 65 today, and one out of five will be over 65 in the year 2030. You know that, and I know that. The baby boomers, every 7.5 seconds one of them is coming on, and none of it can be sustained.

So, it appalls me to have to sit and listen about the poor and the kids and the students and sickness when there will not be anything in the whole kitty, because this is the big one and the big one is not talked about by you, or by us.

The big one is $360 billion a year and going broke in the year 2029. Why do the trustees—and you are one—not give us alternatives on saving the big one so that we can have something left to take care of the little ones?

Secretary SHALALA. Senator, I will shortly. That is, on Social Security, which is no longer in my jurisdiction, I have actually appointed a commission headed by Ned Gramlitch from the University of Michigan. Some of the debate within that commission has already come out in the newspapers.

I have not formally received the report, but when I do it is clear that we are going to have a very lively debate about the future of Social Security. The President feels as you do, and as Senator Moynihan does, that this ought to be a bipartisan debate and a bipartisan proposal.

So on Social Security, to be fair to me, I have, in fact, 2 years ago, recognized the issue. We have been working with Congress and with Senator Moynihan, and we do, indeed, have a report coming out presenting alternatives on Social Security.

On Medicare and Medicaid, the President has presented a balanced budget. We believe we can balance the budget, get reforms in both Medicaid, Medicare, as well as the welfare programs, and do it within the context of a balanced budget. There is no reason why we cannot build in protections to children and move larger and larger numbers of their parents into the work force as quickly as possible.

The only way to do that, we have suggested, is by giving the Governors more flexibility to get there, But, at the same time, the concerns that we have echoed here are concerns not about the Governors getting some flexibility to do that, but whether the financial provisions actually will cost out, whether CBO will score this, their Medicaid proposals, for instance, as a saver, whether the work standards are strong enough, whether the State matching ought to be kept in.

So, we are arguing about how it will get there, but we are not arguing about whether we should get there or, whether we should slow down growth in the entitlements. You and the President do not disagree on any of those issues, or whether we should balance the budget in seven years. Hopefully very soon we will move to an agreement there.

We are arguing, though, about the details of how we get there, about who ought to be protected in the process.

Senator SIMPSON. I would respectfully say that the President rejected every bit of the bipartisan commission's activity on the entitlements.

Senator MOSELEY-BRAUN. I will be very brief, Mr. Chairman.

The CHAIRMAN. A very short question.

Senator MOSELEY-BRAUN. Just for the record, to clarify, I served on that commission. I want to point out to my colleague that what we are talking about right now, the AFDC, is less than 2 percent of the budget. So, this is not one of those things that we were looking at. I think, for the record and for the public, that we ought to be clear that that is not the big ticket item that we were addressing on that commission.

Second, with regard to the Secretary, I would like also the record to be corrected there. I do not know if the Secretary was engaging in a more general conversation when she referenced the million people who would go to work tomorrow but for health care. Under the Family Support Act, health care extension is automatic for a year.

So, it is not as though the people who would go to work tomorrow if they could have health care would lose that health care, they would still get to keep it. I think that is important to note also for those people out there who are the one out of nine looking for those jobs, that they will not lose their health care today if they go into the work force.

The CHAIRMAN. Well, I would just comment, of course, we are talking about Medicaid as well as welfare reform, and of course the budget is made up of many elements, brick by brick. You cannot point the finger at just one, it is the cumulative impact of all of them.

I have, Madam Secretary, a series of questions that I would like to ask, to move forward on the NGA proposal, and I would appreciate if you could be very brief and may be able to say yes or no.

Governor Chiles testified under the NGA proposal that if you are eligible for Medicaid today that, with a few exceptions, you would be eligible under the new proposal. The Governors seemed to acknowledge there may be some current Medicaid recipients who may not be included in the guaranteed population of the NGA proposal. However, these may receive benefits as optional populations, as allowed under the current system.

Would the President oppose any Medicaid proposal which does not mandate coverage for every current recipient?

Secretary SHALALA. Well, I think we have indicated here that we very much would like those adolescents covered, which is part of current law, and that we have deep concerns about the disability definitions, about the fairness of having 50 different disability definitions. We have some concerns which are unclear at the moment.

The CHAIRMAN. Can I ask, when you say has concerns, that means that the answer is no on this point?

Secretary SHALALA. We would like all the people who are currently covered by Medicaid to continue to be covered.

The CHAIRMAN. And would not support legislation that did not do so.

Secretary SHALALA. We would not indicate our support of such legislation.

The CHAIRMAN. Do you support the NGA proposal to lower the Federal Medical Assistance percentage for States?

Secretary SHALALA. What we have suggested on the 40/50 split is that a commission be appointed to look at the total formula. What we are talking about there is historic situations which Sen-

ator Moynihan, Senator Breaux, and Senator Graham, Senator Moseley-Braun, Senator Chafee, and Senator Simpson well know that have been locked in to the current Medicaid formula, into the DISH payments, for example.

We think that it needs a more rational look so that rather than just changing the percentages like that which may lead to some other kind of unfairness, that we ought to take a rational look at that.

The CHAIRMAN. But a commission would take time, and we are trying to move this legislation ahead.

Secretary SHALALA. But the commission could be asked to report within a relatively short period of time, and then some additional changes could be made in the legislation.

The CHAIRMAN. I would just point out, the Governors say it is critically important that whatever action we take be within a month.

Let me ask you this. Do you support changing current law regarding the individual entitlement?

Secretary SHALALA. No. The answer is, no.

The CHAIRMAN. Do you support the NGA's provision on the private right of action?

Secretary SHALALA. As we have indicated, we prefer the private right of action be in the Federal courts. We do support the repeal of the Boren Amendment as part of that. But the individual right of action to enforce the benefits, we believe, ought to continue.

The CHAIRMAN. At the Federal level.

Secretary SHALALA. At the Federal level.

The CHAIRMAN. And it would not be satisfactory at the State level.

Secretary SHALALA. Not at the State level.

The CHAIRMAN. Do you support allowing the States to redefine the treatment services provided by the early and periodic screening, diagnosis, and treatment provision of Medicaid?

Secretary SHALALA. We have indicated to the Governors that that ought to be very much a part. We are talking about the treatment part and how much coverage there would be on the treatment part.

The CHAIRMAN. Yes.

Secretary SHALALA. We have indicated to the Governors that we share some of their concerns about the costs in this area, and we would certainly be willing to talk to them. We are talking to them now about what kind of provisions they would like there.

The CHAIRMAN. Governor Leavitt of Utah has been particularly eloquent about the Federal Government's refusal to allow Utah to restructure Medicaid benefits. He talks about Medicaid being more generous than health care coverage for the typical State worker, which is more generous than the typical worker in the private sector.

Would the administration support a proposal which allows a State to reduce the level of benefits?

Secretary SHALALA. The current system allows the States to reduce or change their optional benefits. I am not sure specifically what the Governors are talking about, but the optional benefits ought to have more flexibility.

The President has indicated that we ought to have more flexibility in the Governors' ability to structure those optional benefits. We would like to keep the current minimum package for health care, which is a standard health care package which most insurance companies would identify. But, certainly, we are in discussion with the Governors about the optionals.

The CHAIRMAN. Would they have to get your approval to reduce the optionals?

Secretary SHALALA. No. We believe that this ought to be part of legislation. Right now, they can change their packages by adding optionals, reducing optionals. But I think they are talking about more flexibility than that, in the definition of what an optional package is.

We ought to have conversations about what we can do in legislation. We would be happy to work with the committee in that area. That is where many of the growth in cost are, by the way, on the optionals.

The CHAIRMAN. Undoubtedly I will want to talk to you further.

Does the administration support allowing the States to define the amount, duration and scope of services?

Secretary SHALALA. We have struggled with that. I think that what we want to know is what the standard is against the amount and duration, whether there is an adequacy standard which is what we currently have in the system.

There is tremendous variability about amount and duration now which the States I think basically come to the Secretary to approve. We have never had any conflict with the States, as far as I know, on that issue. As long as there is some kind of a standard, there can be flexibility in that area.

The CHAIRMAN. Finally, the Democratic and Republican Governors alike have been extremely critical of the current waiver process. They told the committee that the current process is unnecessarily burdensome and arbitrary. Is it true that States have been denied waivers which other States have received?

Secretary SHALALA. Not that I know. It may be burdensome, but it is not arbitrary. One of the reasons they see it as burdensome is because it is not arbitrary, because there are standards.

The CHAIRMAN. What is the period of time that waivers have taken, shortest to the longest?

Secretary SHALALA. Let me give you an example. We have done 60 waivers——

The CHAIRMAN. But I would like to know the range of time.

Secretary SHALALA. Yes. It depends on the complexity of the waiver. We now have a process by which we can do a waiver in 30 days, for example, in the welfare area.

The CHAIRMAN. What is the longest period?

Secretary SHALALA. I am sure the longest is because we took some waivers that were in the previous administration. But, to give you a sense of the volume we have been handling, the previous administrations, the entire number of waivers they did in all the previous Republican administrations, was 11. We have done close to 60, combining welfare and health care waivers. That is a huge number of waivers, but it also tells you something.

The CHAIRMAN. Can I go back, because my time is up, to the range?

Secretary SHALALA. Let me, if I might, Senator. The difficulty between us and the Governors on the waivers is, our waiver authority is for demonstrations. They have to have evaluations, they have to be carefully designed. It is not a waiver authority just to change the program. Congress, in your wisdom, gave us waiver authority for demonstration purposes, to learn something. That means the waiver has to be carefully designed so it can be evaluated. We believe——

The CHAIRMAN. Again, I appreciate that. But Governor Thompson, for example, I think said a request for waiver has taken over 2 years, and he still does not have it.

Secretary SHALALA. We have given the Governor a number of waivers. I could check the timing of the precise one he is talking about, but during this administration we have given Governor Thompson a number of welfare waivers.

The CHAIRMAN. Let me point out, I am not trying to address this to this administration or the last administration.

Secretary SHALALA. All right. Senator, one of the recommendations we have made is that we get out from under the waiver process, both in Medicaid and in welfare in the major areas in which the Governors want to move.

Our welfare reform proposals, similar to some of the things the Governors recommend, do this so they do not have to come to us for waivers on managed care, so they do not have to come to us for waivers on home care, so they do not have to come to us for many of the things that they want to do in the welfare area that have been duplicated that we have already experimented with. We have laid those out in our proposals, and we would be happy to supply you with a length of time record for each record that we have approved.

But I can tell you that we have been both overwhelmed by waivers, and we have an excellent record on getting waivers out. The Governors simply—and I understand this—do not want to come to us for waivers.

The CHAIRMAN. There is no question they want flexibility, and there is a difference of opinion and approach that somehow has to be reconciled.

Secretary SHALALA. Actually, there is not a difference of opinion. On most of the areas where they want waivers, I would say 90 percent——

The CHAIRMAN. But you are not willing to give full flexibility as to duration.

Secretary SHALALA. No. We believe there ought to be an adequacy standard that gives——

The CHAIRMAN. No, I understand that. What I am saying is, those goals, the goal of flexibility on the part of the Governors, and that you want to have some standards, that has to be somehow resolved.

Secretary SHALALA. We believe, for the Medicaid program to be real, that there has to be a real benefit. It is literally that, a real benefit. Therefore, you have to have some type of adequacy standard.

The CHAIRMAN. I think the Governors would agree with that.

Secretary SHALALA. Yes. And they are working on that now. They recognize that. To be fair to them, on a number of these areas that I have identified they are still working on their proposal, talking to us, talking to Congress. Some of them will be resolved, because they recognize the concerns.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. Thank you for that line of questioning which indicates we can work something out here on Medicaid.

May I make a point, to support a comment of Senator Moseley-Braun. Medicaid began in 1965—I was around in the Johnson Administration when it did—to be a supplement to AFDC, Title 4A of the Social Security Act. I think Medicaid is Title 19.

Medicaid is now six times as costly. The costs, of welfare, AFDC, remain at $14 billion. Expenditures are decreasing Federal Medicaid spending, in 1994, was about $80 billion, a very different amount.

The problem here is that this one program that was begun to supplement——

Senator MOSELEY-BRAUN. You mean Medicaid?

Senator MOYNIHAN. Medicaid is $80 billion now, as against $14 billion for welfare for children.

Senator MOSELEY-BRAUN. Yes.

Senator MOYNIHAN. The children do not get any of the $80 billion, other people get it. This began as a supplement. Now we are preparing to drop the program which it was intended to supplement.

Madam Secretary, I do not envy your situation. But last spring in the New York Times—Senator Grassley mentioned the story in the Times yesterday—there was this report. An administration official, speaking on condition of anonymity said, "AFDC is the bone that the Clinton White House can throw to the hounds at the door." To people who want to make radical changes in the welfare state, the bone. Children's bones.

The official said the White House had not made a major effort to preserve the entitlement of poor people to welfare benefits because such an effort would be "more trouble than it is worth" in political terms.

I have been in politics all my life, and I can translate for you, and I think others here can too: children do not vote.

One last question.

Secretary SHALALA. Senator Moynihan, may I respond?

Senator MOYNIHAN. Please, would you do that?

Secretary SHALALA. First of all, I consider that statement outrageous. It speaks for no one in this administration, and it certainly does not speak for the President of the United States.

Senator MOYNIHAN. Well, I am sure it does not speak for you, and it did not say it spoke for the President. It is an administration official, by a respected journalist in a respected journal. We do not have to agree, but I do not suggest it applies to you in the least.

Secretary SHALALA. Well, it does not represent the views of this administration, which is the point I want to make.

Senator MOYNIHAN. Fine. I would just have one other question here, just because of what we are dealing with.

In your statement you say, "Teen pregnancy rates have gone down." It is the first paragraph of your statement on welfare reform. "Teen pregnancy rates have gone down." Well, have they? In any event, let me tell you they have not. They are now about the same as they were 50 years ago.

But the real issue is not rates, but ratios. Now, the out-of-wedlock ratio for teen births is what?

Secretary SHALALA. Gone up, I assume.

Senator MOYNIHAN. It has gone up, and up, and up. It has gone up every year since 1957. It was 13.9 percent in 1957 and in 1993 it was 71.3 percent.

Senator CHAFEE. Pat, could you describe what those percentages are, a ratio to what?

Senator MOYNIHAN. Yes; the teen birth rate is the number of births to teenagers age 15–19 per 1,000 teenagers age 15–19. The teen illegitimacy ratio is the proportion of all births to teenagers 15–19 which occur out-of-wedlock.

For teenagers, birth rates have recent years been going down somewhat, the number of births per 1,000 teenagers. There are fewer children being born. But, of those being born, the number born out-of-wedlock keeps going up. For all teenagers, it is now 71.3 percent in 1993.

Senator CHAFEE. And I think nationally, without restricting it to teenagers, it is something like 32 percent.

Senator MOYNIHAN. 32 percent, probably verging on 33 percent. It was 31 percent in 1993.

Senator CHAFEE. In other words, 33 percent of all births in the United States in America are to unwed mothers.

Senator MOYNIHAN. 32 percent at least, probably getting to 33 percent. Yes.

Senator CHAFEE. And what did you say, 70 plus percent of all births to teenagers are to unwed mothers.

Senator MOYNIHAN. Yes, sir. That, of course, is the most vulnerable population to welfare dependency.

Thank you, Mr. Chairman.

[Figures referred to appear in the appendix:]

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Madam Secretary, I would like to ask you about a series of provisions that are in the Senate-passed welfare bill, passed with a 87–12 vote, that you support. We included an 80 percent maintenance of effort; we added $3 billion in mandatory spending for child care without a State match; we kept the current entitlement and protections for foster children; we made significant reforms to the children's SSI but we kept the full cash benefits for those who remain eligible; we left it up to the States whether they would enact the family cap, something you endorsed in your testimony; we exempt battered women or disabled women from the time limit; we kept the AFDC linkage for Medicaid.

So my question to you is, what is the matter with the Senate bill? Why did you not endorse the Senate bill; what is it that you do not like? You, obviously, will be speaking for the administration.

Secretary SHALALA. Obviously, the Governors had some things that they wanted to add to the Senate bill in their own proposal. I think our preference is to go forward rather than backwards. We were presented with the conference bill, not with the Senate bill.

The Governors have made some recommendations here which we think can strengthen the Senate bill, and we have indicated that we do have some concerns about the Senate bill, including the option on food stamps and the need for a mandatory voucher to protect children.

So I can give you more detail on the Senate bill, but we believe the Senate bill could be strengthened as part of the discussion that this committee has in a bipartisan way. I think the Governors have made some recommendations that would strengthen the Senate bill. We would like to see some of those incorporated, if you are going to work off the Senate bill, and we have some other proposals, too.

Senator CHAFEE. Well, I would look forward to seeing those. As the Chairman mentioned, we have sort of a time urgency. Not sort of, we have a time urgency here. Time is of the essence.

I share the view that Senator Conrad and others have expressed here, that we are familiar with the Welfare bill. We passed it once. Maybe there could be some improvements to it, but I would be interested in receiving those from you and what support you could give to it.

Now, the National Governors' Association has kind of an interesting proposal. It would allow the States to take their foster care and their adoption assistance maintenance payments either as an entitlement or as a block grant. They could switch back and forth.

I worry about that because now, about 22 States are under court order, as has been mentioned, because they have not provided the most basic protections. How many States do you expect would take this optional block grant, and do you think we should allow States under court order to take this block grant in the foster care program?

Secretary SHALALA. First, let me say, Senator, we do not believe there should be a block grant in the fundamental child protection services in this country. We do not think that any State should run out of money in this area, that these are the most at-risk children. I do not think I have any way of estimating, unless Mary Jo Bane does, how many States would take the block grant.

One of the problems is, we do not actually have a level of detail in that particular proposal where we could come to any conclusion for you. When we do, we may be able to. I think that basically we would like to keep this as you would, as an entitlement.

Senator CHAFEE. Yes. When I said it was an interesting proposal, that did not mean approval.

Secretary SHALALA. Yes, I understand that.

Senator CHAFEE. We have heard the Governors many, many times. We have met with them personally, individually, we have met with them as a group, we have had them before the Finance Committee. I want to tick through the principle gripes they have. They have been covered here, but I want to make sure you understand them, as I am confident you do.

First, the difficulty in getting the waivers. That is a constant complaint. Now, one of the problems may be that you have to find these things to be budget-neutral.

Secretary SHALALA. Yes, it is a big issue.

Senator CHAFEE. And I suppose we have provided that here.

Secretary SHALALA. Yes. The last thing you want me to do is grant waivers that are not budget-neutral. The legislation requires a certain kind of budget neutrality. But, in addition to that, they do not necessarily want to do demonstrations, they want waivers for flexibility. So, let us be fair.

Senator CHAFEE. All right. So I think we ought to eliminate this business of demonstrations.

Second, particularly——

Secretary SHALALA. Senator, excuse me.

Senator CHAFEE. Yes.

Secretary SHALALA. I am not sure we want to terminate demonstrations, because beyond where they want flexibility we may still want to try out some new ideas. But the vast majority of things that they are doing now that they want to do, they ought to have the flexibility to do.

Senator CHAFEE. I often wonder on demonstrations that you conduct whether anybody ever evaluates your demonstrations.

Secretary SHALALA. Oh, that is the requirement. That is why we are having arguments with the Governors, many times. It is on the design of a demonstration so that it will lead to an evaluation.

Senator CHAFEE. My time is, I was going to say, nearly up. But if I could just finish this, to tick off the items. The difficulty in getting the waivers. Second, a Cadillac Medicaid plan, which I think Senator Roth touched on.

The Federal courts drive them crazy. I think that is a make-or-break issue with the Governors. They just feel that anybody can race into the Federal court and tie them up, and they feel very, very strongly about that.

Third, the nursing home situation. The nursing home inspections and enforcement provides them with a tremendous headache. Apparently they have State inspections, they have Medicare inspections, Medicaid inspections, Veterans Administration inspections, and on and on it goes. What we can do about each of these items is one of the challenges before us.

Could you just briefly say something in response to the Cadillac Medicaid problem?

Secretary SHALALA. Yes. If the Medicaid program is a Cadillac, then it is a 1965 Cadillac. That is why we are here discussing reforming the program. It is moving rapidly. And, as you know, we have moved through the waiver system large numbers of people into managed care.

We believe the major issues the Governors want addressed, which is what they have asked us for in their waivers, moving people to managed care without a waiver, using home care and community-based care with more flexibility, that those can be addressed by giving them the flexibility in those specific areas.

As to the waiver issue, I have responded on the waiver issue. My view is, the major waiver issues ought to be taken care of by giving them flexibility in the two areas where they have been asking or

waivers where we do not think they should have to ask for waivers any longer.

Finally, on the courts, that has been a Boren Amendment issue. We favor the repeal of the Boren Amendment. It has been the provider suits that have driven them crazy.

As more and more people move to managed care, it becomes less and less an issue because it is not a fee-for-service system anymore, but it is a managed care system. That means they set the rates for the managed care providers and they will not be sued in that area.

As for individual suits, there are very few of them. I think we figured one per State a year for the years of the program. It is really a Boren Amendment issue. I think this committee, and all of us, can address those issues through flexibility, through repeal of the Boren Amendment.

On waivers, I have made it very clear. I want out of what they described as the waiver process. We ought to be doing real demonstrations on real experimental ideas. On managed care, and on the home and community-based care, they ought to go ahead and just do that.

Senator CHAFEE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. I think Senator Moynihan was absolutely correct in pointing out the alarming illegitimate birthrates in this country. I happen to believe that one of the causes for that is the failure of welfare programs in this country to do what is needed to keep families together, to encourage and provide work opportunities.

I think that is the challenge that we have on welfare reform. I think we do need time limits. I feel very strongly about that. But we also have to make sure that when the time limit comes that the person, particularly the children, are still protected with food stamps, with Medicaid health care, and also with vouchers. But I think time limits have to be part of any solution and part of any legislation.

With regard to Medicaid, I mean, the Governors advocate flexibility. But flexibility does not mean irresponsibility on the part of the Federal Government and trying to make sure that Federal dollars are spent properly, appropriately, and for the right things.

I think the key in Medicaid that we have been talking about is, we have to determine who is eligible, second, what they are eligible for, and third, to make sure that that is enforceable.

Now, with regard to what they are eligible for, the Governors have said that what they want is to be able to design the benefit package. I am concerned that, because of the flexibility they have in making some of the determinations, we do not have a standard under their proposal as to judge whether it is adequate or sufficient to meet the needs of adequate health care in this country.

It seems that when the Governors, Madam Secretary, testified, they indicated they were willing to put a standard in there so we could judge whether that benefit package met a standard of some sort.

One of the things that I think was being suggested is a minimum benefit standard which is comparable to what private insurers private, or with what HMOs provide. Is that something that is a possible solution to this problem of having a benefit package and a standard to judge it by?

Secretary SHALALA. It is. The Governors have indicated, particularly after the hearing, their flexibility in this area. All of us ought to work very closely with them. They are already considering this.

I think one of the points that I should make though, in terms of their own costs, only 44 percent of the Medicaid spending is for the mandatory benefits and the mandatory eligible population.

So a lot of their problems are on the optionals, but still, on the basic benefit package, I think there are some design questions there. As long as we have an adequacy standard that we agree on, I think we could work this through, as we can many of the issues the Governors raised.

Senator Roth, I started out by saying they gave us four or five pages. This is their thinking on the issues, and they are working through the details now, I know working with your committee, too. So we need to be fair to them. We think they are moving in a positive direction, but we obviously have some concerns.

The CHAIRMAN. If I just might make a comment on that, because I do want to stress the importance of flexibility of the various groups as we try to put together a piece of legislation that we can get through and enacted into law.

I cannot emphasize how important I think the support of the bipartisan Governors is. I think they have given life to what we are doing today. Whatever we do, we have got to try to keep their strong support for the legislation.

Secretary SHALALA. I agree, Senator.

Senator BREAUX. Well, again, I agree with the Chairman. Flexibility, yes; irresponsibility, no. They should have the maximum amount of flexibility, but we all have to be responsible on what they are being flexible with.

We have an obligation to make sure that the dollars that we have to tax people to use are being spent for something that we can define, not just toss it up in the air and hope it falls down and does good somewhere.

On the eligibility question, the Governors' testimony says their plan would cover pregnant women to 133 percent of poverty, children to age 6 to 133 percent of poverty, children age 6–12 to 100 percent of poverty, and the elderly.

What, concisely, is the concern of the administration with what the Governors say who would be eligible.

Secretary SHALALA. 13–18.

Senator BREAUX. Which is optional, is it not?

Secretary SHALALA. No. It is now being phased in under Federal law a year at a time.

Senator BREAUX. All right. So you would want that as an eligible standard.

Secretary SHALALA. Yes.

Senator BREAUX. Who else?

Secretary SHALALA. And we have to deal with the disability issue, with the disability definition.

Senator BREAUX. Just the definition.

Secretary SHALALA. To make sure that we have a standard there.

Senator BREAUX. They say that they define disability, but the Secretary would have to sign off on it. Could you not issue a blanket statement that says, I will sign off a disability definition that includes the following and nothing less?

Secretary SHALALA. I could, but the preference would be if you were moving in that direction—and we need to talk about this—that you set some standards for that. I would not leave the Secretary out alone trying to set standards through regulation as opposed to careful guidance in this area because that is what we always argue over. But our preference——

Senator BREAUX. Congress could define a broad-based definition of disability and then the States, within those parameters, would be able to come up with their definition.

Secretary SHALALA. Yes. But, again, our preference is to continue the discussion with the Governors, because if the issue is what you dealt with already in SSI, then that could easily be taken care of as part of the definition of Medicaid eligibility.

Senator BREAUX. Well, we need to tighten it down.

Secretary SHALALA. Whatever it is, it has to be tightened down considerably.

Senator BREAUX. I mean, the Slattery Commission, I thought, did a good job in trying to come up with a better definition of disability, and then maybe we ought to take a look at that. What do you think?

Secretary SHALALA. I think that that is exactly the kind of discussion and the kind of information that you would want to take into account. All of you, dealing with the SSI definition, took that into account, because it is very close.

Senator BREAUX. All right. Eligibility of benefits. Again, you have made the comment on the enforcement, and you feel it should be in the Federal courts. The Governors sort of suggested a hyphenated version whereby I think that they would settle the question of enforceability in the State courts, but they would have an appeal by the Secretary to the Federal court.

Secretary SHALALA. Yes. That would get the Secretary into litigation which I am not currently in. It is a Justice Department issue. I think the whole issue of which court requires a broader discussion, not just with the Governors, the health care and the welfare experts, but I would think with the Judiciary Committee this is a huge precedent, to suddenly take away a right to go into Federal courts on a Federal statute.

Senator Hatch has raised the issue and we have asked the Attorney General and the Justice Department to give us advice on this issue. I just think it really requires a thoughtful look, and it is way out of my area of expertise.

Senator BREAUX. Well, I thank you for being with us and your continued willingness to work with us on this. I think it is doable. I think we can get it done, and hopefully we will.

Thank you, Mr. Chairman.

The CHAIRMAN. Just let me, again, underscore that the question of litigation in Federal courts is an extremely hot button, I think, with respect to the Governors.

Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman. Madam Secretary, I would like to move to another area that was contained in the welfare reform bill, and that was the treatment of legal immigrants, and I want to underscore, legal immigrants.

In your testimony, you make the statement that the administration opposes deep and unfair cuts in benefits to legal immigrants. Could you detail what you think are some of the more pernicious, deep, and unfair cuts, and have you assessed what the impact of that would be on a State by State basis?

Secretary SHALALA. Yes. Senator, the Governors have not taken a position as far as I know on the immigration issue, so there is nothing in what they have written that would allow me to answer your question. As you well know, we do have a position on deeming for legal immigrants to citizenship.

We would be opposed to a two-standard, second-class citizen category where people, even after they became citizens, would not be eligible for certain programs because of the way they came into this country.

We believe that deeming to citizenship ought to take care of some of our concerns about people possibly being brought into this country for the purposes of using the social safety net programs, and that there are protections built in there.

But to unfairly treat people as they come into this country would be unfortunate, though there is no reason why we cannot hold their sponsors to what they have agreed to do, and that is to sponsor them.

There obviously would be some exceptions for certain groups—refugees, for example. There are some groups that we have always put in a separate category.

Senator GRAHAM. As you know, the courts have interpreted the current deeming requirements, that is, where the income of the sponsor is deemed to be part of the income of the legal immigrant for purposes of eligibility for means-tested programs, as being virtually unenforceable.

Secretary SHALALA. Yes. You would have to introduce legislation to do that.

Senator GRAHAM. Would it, therefore, be your recommendation that the application of those deeming standards be prospective with the intent——

Secretary SHALALA. Oh, definitely prospective.

Senator GRAHAM [continuing]. Of the prospectivity being when they are, in fact, rendered legally enforceable?

Secretary SHALALA. Yes.

Senator GRAHAM. Maybe the first act that this Congress passed was the Unfunded Mandates Act, which was intended to avoid shifting of responsibilities from the Federal Government to State and local governments.

Would you and the administration agree that the proposals for these deep and unfair cuts in benefits to legal immigrants also constitutes an unfunded mandate shifted from the Federal Government to State and local governments?

Secretary SHALALA. It certainly is a shift to State and local government, whether it comes directly under the Unfunded Mandate

law. You are asking me a specific question of whether we have ruled on that. It certainly seems to fall into that category.

Senator GRAHAM. I would like to ask another question. There is general agreement that in both Medicaid and welfare reform that we will start the process in terms of allocation of funds among the States more or less on the status quo, that is, what States got in 1994 or 1995 will be the baseline to commence this process.

If we accept that, that means that we are going to be accepting very extreme disparities. For instance, there is one State which receives, under Medicaid, benefits for elderly citizens at an average of $21,494 per beneficiary, and another State, for the same type of citizen, receives $4,651. In the area of children, a range would be from $1,931 in one State to $591 in another.

If you accept those disparities based on historic reasons as a necessary beginning point, then I think it is quite a different thing to say that we are going to accept those as being a permanent part of our reformed Medicaid and welfare system.

What would the administration's policy be relative to incorporating in these allocation provisions items that would have the tendency over time to bring the States closer together in terms of what their citizens or their residents receive—they are all United States citizens—for the same type of either health services or welfare services?

Secretary SHALALA. You know we have the Senators from New York and the Senator from Florida sitting here. Florida is a low-cost State that would benefit from a high growth rate; New York is a high-cost State that would be hurt by a lower growth rate.

What we have recommended is an advisory committee to deal with the broad range of issues, including changes in the FMAPs for the States, the potential to set different annual per capita growth rates for States that have high base year costs compared with States that have low base year costs.

The difficulty is our reluctance to lock in the current system when we know that there is unfairness in the current system. But I am not sure pulling down New York while we raise up Florida is the way to solve the issue, as opposed to a much more thoughtful formula.

Senator MOYNIHAN. Now we have finally agreed on something.

Secretary SHALALA. Yes. It requires a thoughtful look. We have recommended an advisory commission to deal with the broad range of issues in this area. It is a very tricky issue, both politically and in just plain fairness to all of you who have struggled with this formula and the impact on your States.

Senator GRAHAM. And I am not, certainly, advocating that this be done in a way that punishes any State, but I am of the belief that you cannot justify as a permanent statement of national policy that we are going to have these extreme differences. Would the administration agree with that?

Secretary SHALALA. We agree with that. We agree with that. Yes.

Senator GRAHAM. And that as we reshape the program, there needs to be mechanisms inserted which will have the effect over time of narrowing the differences.

Secretary SHALALA. Let me say, the differences ought to be appropriate. It is not that we should not have some differences be-

cause of the difference in cost between the States, but the question is, are those differences fair, are they perceived as fair by the States?

To do that within the context of slowing down the growth rate of the programs, we believe that all of us are better off by putting this in a commission. Let them make recommendations to the administration and Congress, and let us get it done.

Senator GRAHAM. Is this one of those recommendations that is going to be put on a fast track?

The CHAIRMAN. I would say to the Senator that we have a confirmation we want to proceed with, too. The hour is late and the Secretary has been very patient.

Senator GRAHAM. Could she just answer the last question?

The CHAIRMAN. Yes.

Secretary SHALALA. The answer is yes.

Senator GRAHAM. Thank you.

Secretary SHALALA. We could put it on a fast track, we could put it in the legislation, we could just do it.

The CHAIRMAN. Thank you.

Senator Moseley-Braun?

Senator MOSELEY-BRAUN. Thank you very much. Madam Secretary, I understand you reacted strongly to the suggestion that was made in an anonymous quote, and I understand that.

So just for purposes of the record and in as clear way as you can, will our President support a welfare bill that does not provide a safety net for children when the time limit comes?

Secretary SHALALA. No.

Senator MOSELEY-BRAUN. All right. Thank you very much. I am delighted to hear that. We all want to do the right thing here, but I just am so concerned about what is going to happen to the children. That is an important, important statement that you just made.

The second issue, and this kind of gets to my colleague from Florida and where he was going with his last question, is the employment situation. I mentioned that my State of Illinois, in southern Illinois, for example, there were nine job applicants for every one job opening.

This is at a time in which my State is experiencing its lowest unemployment rate in years. So the question of job and job placement and job availability obviously cuts to the heart of our responses to poverty.

So, again, in light of the time limit issue, my question becomes, what are the national standards, if any, for the subsistence of children post-time limit, for this administration?

Secretary SHALALA. As reflected in the President's welfare bill, there is a combination of a voucher, food stamps, child protection services. I mean, the whole range of programs are there for the protection of children once the time limits run out.

But I cannot emphasize enough that if we are successful working with the Governors to move large numbers of people into the work force, that we will reduce the number of people for whom we need the safety net after a 5-year period, and that ought to be our goal.

Senator MOSELEY-BRAUN. Well, I could not agree with you more. Moving people into the work force ought to be a goal. Senator

Breaux's point is very well taken. Moving people into stable families and getting beyond this pattern of growing illegitimacy. I think all of these are concerns we want to try to address.

I am just delighted, again, with your response to my first question because the question of what happens to the kids, the children, once all these complications are said and done, is really a bottom line kind of an issue, and I think not just for the members of this committee, but certainly for our country as a whole. Thank you very much, Madam Secretary.

The CHAIRMAN. Just one quick follow-up question. Since food stamps have been opened up, would you support an optional block grant for food stamps?

Secretary SHALALA. We have not, up until now, supported an optional block grant. We believe food stamps is the ultimate safety net for poor families. In particular, our concern about the block grant is, of course, running out of money exactly at the time where working families lose their jobs and need the food stamp support, which is when there is an economic downturn in the State.

So our strong feelings about food stamps being an entitlement, Senator, is reflected in who we know will need the food stamps when the money might run out in a State when there is an economic downturn, and they are working families. They are exactly the kinds of families, losing an entry-level job, that you want to make sure that there is a temporary safety net.

The CHAIRMAN. Well, I have a few follow-up questions, but the hour is late. We will leave the record open for written questions until midnight tomorrow. Or maybe 5:00 p.m. tomorrow; 5:00 p.m. tomorrow. I heard my staff complain.

Secretary SHALALA. I heard mine complain, too.

Senator CHAFEE. Mr. Chairman, could I just make one statement?

The CHAIRMAN. Sure.

Senator CHAFEE. Madam Secretary, I think that the administration is adopting a contradictory policy when, on one hand, you say—and we all agree up here—"our goal is to move large numbers of people into the work force," that is, from the welfare rolls. At the same time, the administration is espousing a significant increase in the minimum wage.

Certainly, as I see it in my own State and I have no reason to believe it is not true nationally, that an increase in the minimum wage reduces the opportunities for people to have something to go to when you seek to achieve the goal of moving into the work force.

Secretary SHALALA. Senator Chafee, I think we just read the economic literature differently in terms of the impact of the minimum wage on the provision of jobs and on what jobs are available for entry-level people, and we will just have to disagree on something today.

The CHAIRMAN. Thank you very much for being here.

Senator MOYNIHAN. May I just make one comment?

The CHAIRMAN. Yes, Senator Moynihan.

Senator MOYNIHAN. We have disagreed on almost everything, Mr. Chairman.

May I place in the record the New York Times story of May 27, 1995 with the statement by an anonymous administration official

that "AFDC is the bone that the Clinton White House can throw to the hounds at the door."

I am glad to hear it repudiated by the Secretary; I never dreamed it was her, and could not be. May I say, it was not repudiated at the time.

Finally, could I just put the administration on notice that Senator Carol Moseley-Braun has said that that disparity of impact between black children and white children, twice as many black children as white children, may very well give rise to a civil rights cause of action.

Thank you, Mr. Chairman.

The CHAIRMAN. The New York Times article will be included in the record.

[The article appears in the appendix.]

The CHAIRMAN. Again, thank you very much, Madam Secretary. We look forward to continuing our dialogue.

[Whereupon, at 12:55 a.m., the hearing was recessed to reconvene on February 29, 1996.]

GOVERNORS' PROPOSAL ON WELFARE AND MEDICAID

(Public Views)

THURSDAY, FEBRUARY 29, 1996

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

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

Also present: Senators Chafee, Grassley, Murkowski, Moynihan, Conrad, Graham, and Moseley-Braun.

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

The CHAIRMAN. The committee will please come to order.

Today we are indeed privileged to have two panels of experts to provide their insights into the National Governors' Association proposal. The first panel will address the NGA proposal on welfare; the second on Medicaid.

Because of the size of the panels, I have told my good friend and colleague, Senator Moynihan, that I would like to limit questions to one round each. Of course, additional questions may be submitted for written responses, and will be included as part of the record.

I have a short statement and then, of course, would recognize Senator Moynihan for his opening statement. But we will ask other Members to refrain from making statements so we can get right to the questions.

This is the third in a series of hearings on the National Governors' Association bipartisan proposals on welfare reform and restructuring Medicaid.

The NGA proposals have sparked an important debate, not only about the future of these programs, but the future of the relationship between the States and Federal Government as well.

Over the next 7 years, the Federal, State and local governments will spend over $2.4 trillion on the current welfare and Medicaid programs.

The Governors have told the committee that the current welfare policies punish parents who work too hard; they punish mothers and fathers who want to stay together; they punish working fami-

lies who have money; and they reward teenagers who have babies out of wedlock.

We also know that if we do nothing to the current welfare system, more children will be on welfare in the future. The family is the cell of society, and Washington has proved that it does not know how to build strong families.

Democratic and Republican Governors alike tell us that the current Medicaid program is overly burdened with years of Federal regulations that have hamstrung the States' ability to provide health care to those in need.

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

We look forward to hearing from the panel of experts who will help us to understand how the NGA proposal might work to change the status quo.

Let me now yield to Senator Moynihan.

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

Senator MOYNIHAN. Thank you, Mr. Chairman. I would just like to endorse everything you have said and to make one distinction which I think is helpful, concerning the size and the rate of growth of the two related programs that we are going to discuss. As I remarked yesterday, Medicaid was established in 1965—the legislation did not go into effect for 2 years, I believe—as a supplement to the Aid to Families with Dependent Children, Title IV–A of the Social Security Act. Medicaid is Title XIX.

Neither was a very significant program at the time. AFDC was a stable, almost receding program. Because it was meant to be a widows' pension, it was thought it would disappear by the time survivors' insurance took hold.

Medicaid was thought to be a modest affair that would never be of any great note. Little did we know the explosion, the sudden onset of single parenthood in the county that would hit suddenly, and has not ceased.

We hear the painful modes of avoidance. I was sorry yesterday that Secretary Shalala began her testimony on welfare by saying, "The teenage birth rate is declining." That is supposed to make you say, "oh, I see. That is getting better, is it?" Well, the birth rate is slightly declining; it has been declining for years. It was 62 percent higher in 1957. I should have added that. At the same time, the teenage illegitimacy ratio goes up and up and up. It has gone up every year since 1957.

The total costs of AFDC have not gone up remarkably. They are at $14 billion annually. Benefit levels have gone down in most States. In real, constant dollars, benefit levels are down. Caseloads and expenditures are declining.

Medicaid, by contrast, has roared upward. I think I said to you, sir, if you make a little geometric progression that, in the 8 years of President Reagan's tenure, the cost of Medicaid doubled. In the 4 years of President Bush's tenure it doubled again.

At that rate, Dr. David Podoff, our senior economist behind me, calculates that it will double again in one day on December 29 of

this year. Now you have got to do something about that. That is your assignment, Mr. Chairman. I have defined the problem; now you work at it.

Thank you, sir.

The CHAIRMAN. As I said yesterday, this is a bipartisan problem, and we seek a bipartisan solution. But you have underscored, Pat, very vividly the problem. I think Medicaid alone is taking up something like 20 percent of the average State budget, which is very significant and has an impact on what the States are able to expend in other areas such as education.

So we look forward to working with you in an effort to resolve this difficult problem.

I will now call upon the first panel to discuss the NGA proposal on welfare reform. Let me start out by welcoming each and every one of you. We are very pleased that you could be here with us.

I think this panel includes a very distinguished group, including Robert Carleson, who served as director of the California Department of Social Welfare under then Governor Ronald Reagan, and as the U.S. Commission of Welfare; Dr. Sheldon Danziger is a professor of social work and public policy at the University of Michigan; Rev. Alfred Kammer is president of Catholic Charities U.S.A.; and Heidi Stirrup is director of Government relations for the Christian Coalition.

We are asking the witnesses to summarize their testimony in 5 minutes each. Your full statement, of course, will be included as part of the record. Then the Members will each have the opportunity to ask 5 minutes of questions.

Do you have any preference? Why do we not just start with you, Mr. Carleson?

STATEMENT OF ROBERT B. CARLESON, CONSULTANT IN PUBLIC POLICY, ARLINGTON, VA

Mr. CARLESON. Chairman Roth, Senator Moynihan, thank you for the opportunity to testify today in support of the historic policy position on welfare reform of the National Governors' Association, which was adopted unanimously—and I repeat, unanimously—by them on February 6, 1996. And February 6 was Ronald Reagan's 85th birthday, and I think it was very appropriate.

In fact, I have been working on the welfare issue since August, 1970 when then Governor Reagan drafted me into welfare, first as a member of his welfare reform task force and then, as you indicated, director of the California Department of Social Welfare, where we had the very successful welfare reform of 1971 and 1972.

In fact, I was honored to sit with Governor Reagan at this table when he testified before this committee on February 1, 1972, in opposition to the Nixon Family Assistance Plan, and putting forward alternative welfare reforms.

Under Cap Weinberger, I was U.S. Commissioner of Welfare. And later, I was Special Assistant to the President for Policy Development in the first Reagan term.

I might emphasize that I left the White House in 1984, and I was not involved in the 1988 legislation that was pushed so successfully by Senator Moynihan.

Since 1971, Ronald Reagan and I have had several lengthy discussions about welfare reform. It has been his most fond dream that the Aid to Families with Dependent Children program be replaced with finite block grants to the States, with no Federal strings attached.

I have been working to this end for most of the last 25 years. We are now close to achieving 90 percent or more of his goal. We may never have this opportunity again. And it was a near miracle that the National Governors' Association unanimously adopted a welfare reform plan which would virtually enact Ronald Reagan's dream.

Predictably, it is being aggressively opposed by the same welfare industry which has so long fought Ronald Reagan every step of the way.

But we should not quibble about truly insignificant details, and let this opportunity slip away—maybe forever.

Those who worry about the budget should observe that the repeal of this historically uncontrollable—and that is what they used to call it—open-ended program, and its replacement with finite appropriations will for the first time make it eminently controllable.

Without this change, any budget numbers, however they may appear to be cut or reduced, will be based on ephemeral policy changes which will be meaningless, and which have historically resulted in increased expenditures. See the 1988 welfare reform.

The additional spending called for in the Governors' plan would be finite appropriations, and thus controllable, well worth it from a budget point alone because of the repeal of the open-ended, uncontrollable current system.

For those who worry about illegitimacy and the family cap, do not let the perfect defeat the good. Contrary to articles written by Robert Rector of the Heritage Foundation, the Governors' plan does support marriage and condemns illegitimacy by supporting the findings and purposes section of H.R. 4, unchanged.

These findings and purposes are the most detailed and complete statements ever made by the Congress in support of marriage and in opposition to illegitimacy.

Current law permits no family cap unless a Federal waiver is given. Although 20 States have been given these waivers, they have been slow to be granted and are burdened with conditions and definitions which make them expensive and often self-defeating.

The Governors' plan gives the States complete control, without the possibility of interference from the Federal Government. In other words, the States will be free to implement and adopt family caps.

With no reform, in my opinion State waivers will end as soon as it is politically expedient. Holding out for a mandatory State opt-out provision is a distinction without a difference and would kill welfare reform, thus retaining the current prohibition of a family cap.

In this year of Ronald Reagan's 85th birthday, the Governors' welfare reform plan should be passed quickly, without change, and laid on the President's desk. No changes should be made to ensure that no excuse can be given for any Governors who may be pressured to back off their commitments to do so, or for the President to use his veto.

In summary, the Governors' welfare reform plan is not a compromise of Ronald Reagan's dream of true welfare reform. It achieves at least 90 percent of his dream. We must not let this historic opportunity slip away. Any statements to the contrary come from people who do not know Ronald Reagan's long-held views on true welfare reform. I do.

The CHAIRMAN. Thank you.

Dr. Danziger?

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

STATEMENT OF SHELDON DANZIGER, PH.D., PROFESSOR OF SOCIAL WORK AND PUBLIC POLICY, UNIVERSITY OF MICHIGAN, ANN ARBOR, MI

Dr. DANZIGER. Thank you, Mr. Chairman, Senator Moynihan, and the other Members of the committee, for the opportunity to testify this morning.

The key point I want to emphasize is that welfare reform must be considered in an appropriate context. That context is an economy which has generated slow growth in wages and rising inequality for the past two decades. These negative economic changes affect middle class managers who have been downsized and factory workers who have been displaced, as well as welfare recipients who are seeking to enter the labor market. They make the achievement of meaningful welfare reform more difficult.

We need to transform welfare from an entitlement to a welfare check into an entitlement to the opportunity to work. That would change the program into the original vision that President Johnson announced for the War on Poverty, when he declared—"We do not want to provide a hand out," he said, "we want to provide a hand up."

Welfare recipients should be expected to look for work. But, if they diligently search for work without finding a job, they should be offered an opportunity to perform community service in return for continued welfare assistance.

The primary reason that I oppose the National Governors' Association plan is that it does not provide any assistance to recipients who search diligently, but cannot find an employer to hire them. The plan would eliminate any assurance that families in need receive assistance. It imposes time limits, but does not guarantee a work-for-assistance alternative for those willing to work.

States could eliminate benefits for two-parent families, sharply reduce the level of benefits, or turn away some of those who are eligible in response to a recession or other State budget crisis.

If the Governors' plan were to become law, given the nature of the labor market, many recipients who are willing to work and take responsibility for their families would find themselves without any cash income.

Everyone agrees that there are problems in our current safety net programs. However, we tend to overlook the fact that they help millions of families who have been unable to support themselves in the labor market.

In sum, the Governors' proposal does not do enough to raise the employment prospects of welfare recipients. It would allow the

States of significantly reduce their own spending, and thus lead to an increase in our already high child poverty rate.

The Governors' program is also likely to lead to reductions in total State spending. A recent review of the literature suggests that there could be as much as a 20 percent decline in the basic cash grant in the first few years following passage of a block grant.

In fact, several States have already announced their intention to cut welfare benefits significantly. And, as Senator Moynihan pointed out, welfare benefits have eroded significantly in real terms over the last 20 years because they have not been increased by the States. Inflation has increased and, in many States, benefits cuts have already been put into place.

There is also no evidence that the reduced State spending on cash assistance would be used to increase State spending on welfare-to-work programs.

The Office of Management and Budget has shown that the conference version of the welfare reform plan that President Clinton vetoed would have added an additional million and a half children to poverty. I believe that if the Governors' proposal were to become law, States would withdraw even greater amounts of funds, causing the child poverty rate to increase even further.

I mentioned the economic hardship which has affected many workers and has made it more difficult for those with less education and less experience to find jobs. This hardship is due to changes on the demand side of the labor market.

Welfare reform however, only affects the supply side of the labor market by increasing the incentive of welfare mothers to search for work. But it's employers, who control the demand side of the labor market, and they increasingly require diplomas, experience, job skills, and references.

In a recent study of newly available jobs, employers were asked about what they were looking for when they posted jobs that did not require a college degree. About half to two-thirds required, on a daily basis, reading of paragraphs, performance of arithmetic, dealing with customers and use of computers.

Many welfare recipients, especially long-term recipients who would be subject to benefit time limits, have limited education and labor market experience, score poorly on tests of basic skills, and are disproportionately located in low-income, inner city communities with few job opportunities, and from which they have difficulty commuting.

Lack of information about suburban vacancies and racial discrimination also diminish their prospects. This means that if we want welfare mothers to work, we must encourage them to search for work, and welfare reform certainly can do that. But unless we provide an opportunity to work, many of them will find themselves with no way to support their families.

Given the current budgetary context, I realize that it is difficult to propose low-wage public service jobs of last resort. Yet, this would clearly be the best way to provide employment opportunities for the poor.

However, a less-expensive alternative can be found. In my State of Michigan, Governor John Engler has proposed that recipients

who cannot find employment can perform community service in return for cash assistance.

This provision is important because it guarantees that a recipient who looks for work, but cannot find employment, can still has an opportunity to support her family. Such a provision should be added to the Governors' Association proposal.

Thank you for this opportunity to testify.

The CHAIRMAN. Thank you.

Reverend Kammer?

[The prepared statement of Dr. Danziger appears in the appendix.]

STATEMENT OF REV. ALFRED C. KAMMER, S.J., PRESIDENT, CATHOLIC CHARITIES USA, ALEXANDRIA, VA

Rev. KAMMER. Mr. Chairman, thank you for the opportunity to testify before the committee.

Catholic Charities USA is a national association of 1,400 independent Catholic charities, agencies and institutions, with 234,000 staff and volunteers serving over 11 million people in 1994.

Many people were stunned last year by the vehemence with which the Catholic bishops and Catholic charities leaders rejected the welfare bills approved by the House and the Senate. The opposition of Catholic leaders was not limited to a few details, but to the flawed philosophical basis of the proposals.

The opposition of Catholic Charities USA to the 1996 Governors' plan rests on the same principles and our 200 years of U.S. experience.

In our Catholic view of human rights and human dignity, government all levels must play key roles in assuring that jobs are available for workers, and that adequate income is available to those who cannot be expected to work—the old, the sick, the disabled and children.

With regard to poor families, in our tradition parents have responsibility to care for and financially support their children to the extent that they are able. And because parents have that responsibility, they also have the right to expect that Government will create the conditions under which they can fulfill their responsibility.

This means that the national Government should not only promote full employment, but also that Government must ensure that adequate assistance is available to those who cannot find jobs at decent wages. And that role is precisely what would be repealed under the NGA plan.

In our view, the Governors' plan, like the 1995 congressional plan, has four fatal flaws.

First, it would repeal the Federal guarantee of protection for poor children, and it would allow the States to turn their backs on poor families.

The Governors' plan repeals the entitlement for individual children to assistance when their parents are destitute, and it does not replace that right with a right to a job, or training for a job, or any other means for parents to support their children.

By repealing the rights of children to Federal assistance, the Federal Government would begin to treat children after they are

born as Federal law now treats children before they are born, as non-persons, undeserving of Federal protection of their lives and dignity.

The second fatal flaw in the National Governors' plan is that it would repeal the right of individual children to receive protection against abuse and neglect. As you know, Mr. Chairman, 22 States are under court order because of their failure to have adequate staffing and other resources to protect children.

Recently, the New York Times reported that in New York City workers falsified records to hide the fact that children were lost in a foster care system for years, without so much as a visit from a caseworker to determine if the children were alive.

Based on our experience, many more children's lives will be in jeopardy if Congress repeals their Federal rights to protection.

We see these cases close up when untrained and understaffed State and local welfare departments fail to remove children from dangerous situations, fail to move for termination of parental rights to free children for adoption, and fail to give families the help they need to stay together in safety.

We get the burned and battered babies, the traumatized toddlers, and the seriously disturbed adolescents on our doorsteps, often too late to fully heal or even comfort them.

The right to go to Federal court to compel States to protect children is critically important. If you repeal that right, this Nation's most vulnerable children will be in even greater danger.

The third fatal flaw in the NGA plan is that it retains rigid and arbitrary time limits for welfare assistance. Families could not receive assistance for more than 5 years, or 2 years, or even less at State option. And States would have no responsibility for providing alternate assistance or jobs for the parents.

Let me be clear. Catholic Charities USA supports reasonable work requirements for parents on welfare, so long as safe, affordable child care is available.

Our experience with families on welfare has taught us that there are three main obstacles to welfare recipients getting jobs, not laziness, but fear of failure and rejection, lack of job opportunities, and inability to hold onto low paying jobs when all AFDC child care and Medicaid benefits expire after 1 year.

The Governors' plan does little to address any of these obstacles.

In addition, rigid and arbitrary time limits would leave millions of children with no support, no hope and no help. We cannot understand how this Nation could deny additional welfare assistance to children whose only crime is that after living on welfare for a total of 2 years or 5 years, their parents still cannot find jobs.

Some have argued in this room that the churches and charities will pick up the slack when welfare time limits and other budget cuts are implemented. However, the churches and charities that are in large scale anti-poverty work have all disputed that notion.

Charities and religious organizations are already reeling, and this committee's recommended cuts are only part of a big, ugly picture of anticipated cuts in food, housing, health care and emergency services.

To get a sense of just how much slack the charities and religious groups would have to pick up, we divided the total amount of pro-

posed Federal cuts in programs for the poor by the total number of churches, synagogues and mosques in America big enough to have a telephone. Over 7 years, the total cuts would amount to almost $2 million per religious congregation—$250,000 a year.

The fourth fatal flaw in the National Governors' plan is that it retains a State option for a family cap and denial of welfare for children born to teenage mothers.

And the record in New Jersey, if I can summarize, is this. If there were 100 women on welfare who might become pregnant this year, based on the New Jersey experience, four children will be aborted, 90 children born into worse poverty, and perhaps six children not conceived. We find this to be an unacceptable outcome for public policy.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Stirrup?

[The prepared statement of Reverend Kammer appears in the appendix.]

STATEMENT OF HEIDI H. STIRRUP, DIRECTOR OF GOVERNMENT RELATIONS, THE CHRISTIAN COALITION, WASHINGTON, DC

Ms. STIRRUP. Thank you. Mr. Chairman, members of the committee, I am Heidi Stirrup, director of government relations for the Christian Coalition. Thank you very much for allowing me the opportunity to appear before you to offer some comments on the proposed Governors' plan to reform the welfare system.

In the interest of time, I would like to summarize my testimony, and ask that my entire written statement be submitted for the record.

Speaking on behalf of Christian Coalition, I would like to point out to this committee that what we believe is necessary for true welfare reform are policies that will discourage dependency and restore a sense of personal responsibility, control costs and reduce the illegitimate birth rates by promoting stable, two-parent families.

Programs that were once judged by the height of their aspirations now must be reconsidered by the depths of their failures and the magnitude of their casualties.

I do not think anyone here is prepared to defend the current welfare system as is. Over $5 trillion has been spent over the last 30 years. And, as a result, America has a larger poverty element that is more violent, more poorly educated, and includes many more single-parent households than ever before.

This is a national travesty, and it is time to try something different.

Rather than advocate policies intended to reduce out-of-wedlock childbirth, the Governors chose to ignore the subject altogether, and instead advocate more spending on benefits, day care, job training and other welfare services.

Instead of offering a vision to reduce dependency, Governors recommend ways for more Federal money to provide more social services to the ever expanding dependency population.

What the Governors fail to recommend are any policies designed to save marriages or remove the economic incentives and reward for single parenthood.

The central problem with welfare, in our view, is the fact that it subsidizes, and therefore promotes self-destructive behavior.

Right now, the welfare system promotes non-work, illegitimacy and divorce. It undermines the work ethic and family structure, and results in more and more people dependent on Government aid.

Few will dispute the fact that there is a moral and social decline in America today, beginning with the decay of the very basic unit of our society—the family.

The basic family unit has been under attack from illegitimacy, promiscuity, adultery, divorce and homosexuality. It is the increasing rate of out-of-wedlock births, however, that is particularly shocking and troubling, and which demands attention.

Our Federal public policies should encourage marriage, help families stay together and discourage out-of-wedlock births.

Welfare cash assistance provides a perverse economic support system for illegitimacy. A young girl on welfare can get a cash grant, food stamps, medical care, day care, a transportation allowance and, in many cases, a rent allowance.

To many, welfare is more attractive than entry-level jobs. It subsidizes unwed motherhood and makes husbands quite dispensable.

According to a report by the Heritage Foundation, one in every three children were born out of wedlock last year. Out-of-wedlock children are seven times more likely to be poor. And girls born out of wedlock are five times more likely to give birth out of wedlock themselves.

Illegitimacy feeds poverty and itself. If we ever hope to reduce the dual trends of welfare dependency and family breakdown, then we must address illegitimacy.

Some would argue that, while this may be a laudable goal, true Federalism and block grants should not impose requirements on the States. And, if left alone, Governors will come up with their own innovative solutions.

I would argue that they have that freedom now. And the fact that the Governors' proposal not only recommended elimination of the family cap, it offered no other alternative, suggests to me that they are reluctant to effectively deal with this crisis.

What we would recommend to Congress to improve upon the Governors' proposal would be to, first, restore the requirement to prohibit States from using Federal funds to give additional cash benefits to welfare recipients who have additional children, but allow for vouchers for the care, feeding and material needs of the child—the so-called family cap.

Second, change the reward/incentive mechanism, and treat all means of reducing dependency equally, and do not rely so heavily on work alone.

Third, increase funding for abstinence education. There is no question that successful practice of abstinence will reduce the number of out-of-wedlock pregnancies.

Fourth, require States to devise their own plans to reduce out-of-wedlock births.

And, fifth, fix the existing illegitimacy ratio bonus plan so that States can more successfully lower their illegitimacy ratio.

We commend the Congress and this committee for their tremendous effort in making an attempt to change welfare as we know it. We encourage you to include policies that help people help themselves.

If we do not save marriage so that children can be raised in two-parent households, we will have done a great disservice to our children and our society.

Thank you very much.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Stirrup appears in the appendix.]

The CHAIRMAN. For the benefit of members of the committee who were not here at the opening, we will limit the one round of questions to 5 minutes, and then ask that any additional questions be submitted in writing so that they can be part of the record.

We have two panels of four each. So time is of the essence.

Over the course of our hearings, a good deal of attention has focused on four important provisions of the NGA proposal.

There is an overall concern that States will shift significant costs to the Federal Government. So I would like to ask each of you to comment on these areas.

I will propound two questions and, if we have the time, will ask two more. Otherwise, I will submit them to you in writing.

Some contend that States will reduce their contribution to the welfare system. What is an appropriate maintenance-of-effort requirement? And will a low State maintenance impose additional demands on the Federal Government?

The second question is that the Governors have requested additional child care funds, although work requirements have been reduced. They also do not want to have to match all child care funds. Is this an area which should be tightened up as the NGA proposal is drafted?

I will ask you, Mr. Carleson, to start. Then we will just go in the same order in which you spoke.

Mr. CARLESON. Yes. Mr. Chairman, first of all, I do not believe that the States will significantly impose or use Federal money to replace State money that is being used in these programs.

Up until recently, actually only a few years ago, the States were free to eliminate their welfare benefits. They could reduce their AFDC benefits to one dollar per family. They have could have raced to the bottom for most of the last 60 years. But they did not race to the bottom.

So when we talk about racing to the bottom, all of a sudden they are going to be given the freedom to do this, they have had that freedom for most of the last 60 years, and they have not done it. So I do not believe they are going to do it.

The second point is that the Governors are elected by the same people that elect you gentlemen and ladies. And I might say that, in fact, there are several Governors on this panel, former Governors on this panel. And they are responsible to the same people that the Senators are. I have heard every one of the Governors I have talked to say that they are insulted when people assume that

they are not going to treat the poor people in their States as well as the Congress would treat them.

This is not 1935. This is 1996. When people talk about the States' failing to do it in the past, they are not recognizing the fact that there have been major changes.

On your second point, I believe that the maintenance of effort that is in the legislation is appropriate. If you had a maintenance of effort of 100 percent, then the States would not be able to receive the benefits of a lot of savings they are going to be able to produce when they get the freedom to design their own programs.

So I think that the maintenance-of-effort requirement that is in the legislation proposed by the Governors is appropriate.

In the area of child care——

The CHAIRMAN. I would ask you to be brief.

Mr. CARLESON. All right. In the area of child care, no, I do not believe there should be a Federal match. There never should be a Federal match because what that does is set priorities within the States to increase spending in certain areas rather than in other areas.

Whether there is a maintenance-of-effort requirement, I would not comment on that. But if it is, it should not be anywhere near 100 percent.

The CHAIRMAN. The question, of course, is should the State match?

Dr. Danziger?

Dr. DANZIGER. I want to talk about how the removal of maintenance of effort and matching requirements will induce States to shift resources away from welfare. States will reduce their own spending, given the kinds of pressures State budgets come under, particularly during recessions. We have a very recent example of States' reluctance to use their own money.

The Family Support Act of 1988 made available Federal funds which States could use on a matching basis. A substantial amount of those Federal funds went unused because States were unwilling to put up their own money as "match" to put more people into welfare-to-work programs.

Even though States were given an incentive to bring additional Federal funds with their staffs in return for putting up some of their own money, many of them did not do so.

A second example of how States use Federal money comes from the CETA program, which came under a lot of attack in the 1970's. States were very clever in finding ways to use CETA funds to hire workers they would have hired in any event. They used Federal funds to replace spending that they would have done anyway. The same kinds of results are likely to emerge if the NGA proposal were to become law.

The CHAIRMAN. Reverend Kammer, please?

Rev. KAMMER. Mr. Chairman, I think the record is, as Senator Moynihan noted, that for 30 years State benefits in AFDC have been declining. I am a Southerner, grew up in Louisiana, worked in Georgia and Louisiana primarily before coming here. The record in the South is abysmal. A mother with two children in Mississippi gets $120 a month to try to live on. And it is almost as bad in my home State and many other States.

And there are current plans in the news the last couple of days of States preparing to take advantage of the Federal largesse that will be available under block grants to shift money out of social welfare.

I mean the record is there, and I think there is a need for a commitment on the part of the States to maintain the partnership with the Federal Government which the Congress required because the Congress has, in fact, has shown itself consistently more caring for poor families.

I would set the standard of maintenance at least 90 percent of the past spending at the State level.

The CHAIRMAN. Ms. Stirrup?

Ms. STIRRUP. Just a quick point, Mr. Chairman. I would suggest, with regard to the additional child care funds and the lower work requirements, that perhaps the better way to go is to target work requirements.

My understanding is that 50 percent of welfare mothers have children over the age of 5. So if the concern is insufficient funds for child care, perhaps the requirement for those mothers that have children over the age of 5, who presumably are in some sort of school, would be the better way to target the limited child care funds.

The CHAIRMAN. Thank you.

Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, I would first thank each and every one of our panelists for a very thoughtful and challenging set of propositions.

I want to thank Rev. Kammer in particular for the marvelous book of yours, "Doing Faith Justice." It was really sort of an epiphany for this Senator.

I have a question for which I do not think any of you have an answer. I would like to raise it even so, and to take just a small disagreement with my friend, Carleson, over there. We have known each other for the longest, longest while.

You say about the Governors' plan, "Predictably, it is being aggressively opposed by the same welfare industry which has so long fought Ronald Reagan every step of the way."

No, it is not. There is no more conspicuous fact of this debate than the silence of the previously vocal, and sometimes strident voices defending one Federal program or another.

One body, one sector of Americans concerned with social policy, has been alert and active. And these are the churches of the United States, the synagogues and the mosques.

It is extraordinary that every national church and charitable group, with the exception of Southern Baptists, called on the President to veto the conference report on H.R. 4—the U.S. Catholic Bishops' Conference, the National Council of Churches, which represents 32 Protestant and Eastern Orthodox denominations, the Congress of National Black Churches, representatives of the Orthodox, Conservative, and Reform Jewish Congregations, the American Friends, the Unitarians, the American Muslim Council. Everybody else has been silent. Oh, some pro forma one-page pronouncements, but no real energy.

I do not understand the despondency out there. There is a real sense that the current welfare system is a failure. Yes, we have failed. But if you say things could not be worse, I do not think you have a sufficient understanding of the human experience. Damn sure, things could be worse.

Yesterday we produced some data. If we enact this year a 5-year time limit, then in the year 2001, suddenly 3,552,000 children would lose benefits.

By 2005, it would be 4,896,000. And what stuns you is that, of these children, half would be black, 49.3 percent. And 19 percent would be Hispanic. Sixty-eight percent would be black or Hispanic.

Senator Carol Moseley-Braun said that the disparate impact of legislation of this kind might occasion a civil rights course of action. These are not perhaps surprising numbers to you, but I would just ask in the seconds you have left, do these numbers not in some way affect the nature of this debate?

Mr. CARLESON. Senator Moynihan, very quickly, the 5 years and out in your provision, I think something similar to that was proposed by the President when he was running for office.

Senator MOYNIHAN. That is right.

Mr. CARLESON. So that is a bipartisan issue. But that provision in the Governors' proposal permits 20 percent to be excepted from that. And, of course, beyond that point the State can use its own money. And of course they are financing half the program now, so they can go even beyond that 20 percent. So this 5 years and you are out is not an absolute.

Senator MOYNIHAN. Bob, we know that. I just leave the question, and hope you will take it away with you.

Dr. DANZIGER. The bell rang. Can I respond to Senator Moynihan?

Senator MOYNIHAN. Can he respond?

The CHAIRMAN. Yes. Sure.

Dr. DANZIGER. Senator Moynihan, when you said that things could be a lot worse, you were correct. When some people talk about how much government is spending and how much poverty remains, they falsely conclude that welfare causes poverty. I often have the feeling that these critics also blame the trade deficit or many other problems on welfare.

If one analyzes the data one finds that welfare and other spending reduce poverty. We do have a high child poverty rate, but it would be much higher without the earned income tax credit, without food stamps, without AFDC and our other social welfare programs.

The primary reason poverty remains high is because for two decades the economy has grown slowly and unequally. These economic changes have affected all workers, including poor workers. Government programs have had to work harder and spend more on more families just to keep the poverty rate from rising even more.

A reading of the research evidence from a variety of nonpartisan sources would show exactly what you said—that things would be a lot worse if we cut back on the safety net.

Rev. KAMMER. We were serving 3 million people in 1981. We are now serving over 11 million people. One million in 1981 needed

emergency assistance, food and shelter; now it is over 7 million. It is a 700 percent increase in 13 years.

We see the results of deinstitutionalization, the budget cuts of the 1980's and the economy, as the professor just said. We anticipate these figures could grow. The number of people who are homeless in our shelters, and women and children in our shelters and on the street have grown enormously. So that is why we have been speaking out for the last year. We have great fear that this is the reality we will face, based upon the reality of the past 15 years.

Senator MOYNIHAN. Thank you, Mr. Chairman.

Thank you all.

The CHAIRMAN. I would just like to include what was said yesterday by the Secretary. When these figures were shown, she pointed out that the figures did not take into account the fact that some welfare recipients could find work or options for States to exempt part of their caseloads from the law.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Ms. Stirrup, in your testimony you have argued in favor of a mandatory family cap, and it is my understanding that the only State which has studied the family cap is New Jersey. The data there shows that it has no impact on birth rates. In fact, the only thing the data shows is that the abortion rates for welfare mothers has increased under the family cap.

I am curious why you would advocate the family cap, in view of those studies in that situation?

Ms. STIRRUP. First of all, I think that the recognition that out-of-wedlock birth is a great predictor of poverty is an important one. I would suggest that the data from New Jersey is conflicting, and it is premature. Initial reports show that in fact, or I had read that in fact, the illegitimacy rate had dropped by 11 percent.

I think the point is not so much that the debate should be whether or not we have a family cap. It should really be what are we doing, and what do we propose to do that will help encourage marriage, save marriage, and provide stable two-parent families for children that are desperately in need of such.

Senator CHAFEE. Dr. Danziger, it appears in the testimony we have here, not only this morning but at other times, that there seem to be two approaches on how to reform the welfare system.

There are those who think one way is to reduce the out-of-wedlock births. And I might say that the statistics we have on the out-of-wedlock births are just shocking. I second everything you say, Ms. Stirrup.

Yesterday the testimony was of teenagers. See if I have these right. Senator Moynihan had evidence that 70 percent of the births to teenagers were out of wedlock in the United States.

Senator MOYNIHAN. Senator, would you like a chart? We have a chart for you here. I will pass this over if you like.

Senator CHAFEE. All right. And that is of births to all teenagers in the United States, 70 percent are out of wedlock.

Senator MOYNIHAN. Seventy-one. The dramatic rise begins in about 1961.

Senator CHAFEE. Of all births in the United States—not just to teenagers—31 percent are births out of wedlock. So we have just got a horrible situation on our hands in the United States.

Senator MOYNIHAN. John, do you see how it breaks in 1961?

Senator CHAFEE. I do not know what that can be attributable to.

Senator MOYNIHAN. Well, if you knew, you would know something every important.

Senator CHAFEE. But I do not know it.

It is amazing. This is births to teenagers. It is absolutely flat at 13 percent from 1940 to 1960, and then it just takes off at an absolutely steady rate. Actually, something went wrong in the country in 1961. I do not know what it was.

Senator MOYNIHAN. Now, careful.

Senator CHAFEE. Let's see—I am trying to figure. I was running for Governor that year, but that did not cause this situation.

So on one side of the equation, doctor, we have those who worry about the out-of-wedlock births, and somehow we have got to reduce it.

And on the other hand, there are those who say this is impossible, but let us concentrate on job opportunities and affordable child care. And you seem to be in the latter camp. I am not saying you are disdaining the out-of-wedlock birth situation, but at least in your testimony you did not concentrate on it.

So what do you say to those who say we will concentrate on where the problem is, namely the out-of-wedlock births?

Dr. DANZIGER. Senator Chafee, thank you for the question. It is important to realize that we recognize that our economy and our society face a number of complex problems. The decline in the numbers of two-parent families is a problem that affects society at large. This is not just a welfare issue. There are many changes in women's economic roles, changes in social stigma and how single parents and out-of-wedlock mothers are treated in society, changes in male earnings' levels that all affect marriage, divorce, and childbearing decisions.

Most scholars who have studied the problem conclude that welfare plays a very, very small role in the trends toward single parent families and the trends toward out-of-wedlock childbearing.

We ought to try to reduce nonmarital births. That is an important issue, that can't be dealt with primarily by welfare reform. How can we best do that? Do we need more family planning? Do we need more sex education? Should we have more abstinence education as Ms. Stirrup suggests? Do we need to increase job opportunities for young men and women? That is not the central issue in welfare.

Senator CHAFEE. Well, there are those, of course, who would differ with you on that. They would say that is the central issue.

Dr. DANZIGER. Well, I would argue that——

Senator CHAFEE. As Ms. Stirrup said, and we have had tons of evidence here, that if a teenager has a child out of wedlock, the chances for health problems and definitely poverty is involved—will come about as a result of this situation, lack of education. The whole thing spirals.

Dr. DANZIGER. What I would like to emphasize is that children growing up in poverty, in neighborhoods where schools are inferior,

in neighborhoods that are dangerous, whether or not they live in a two-parent or a one-parent family, will have great difficulty obtaining the skills they need to make it in the current job market.

And, given labor market barriers, they have great difficulty finding jobs at all, or jobs that pay good wages. I believe that the welfare program can change from a cash safety net to a work-oriented safety net. I believe that if there were more educational and employment opportunities, there will be some modest reduction in out-of-wedlock childbearing.

But I think, as Father Kammer cited from the recent New Jersey welfare experience, that there is just not much evidence that changing welfare is going to have a big effect on the numbers of children living in single-parent families. Senator Moynihan has for years been showing that the trend toward single parenthood is a society-wide problem. Most people who have children out of wedlock are not welfare recipients.

The CHAIRMAN. Senator Conrad?

Senator CONRAD. Mr. Chairman, I thank this panel. I am very sorry I was not able to be here for all of your testimony, but I had a group from North Dakota who were here, and the only time I could meet with them was in the middle of your testimony. So I apologize for that.

I have had a chance to review the testimony, and I think this panel is excellent. I very much appreciate the effort that went into your presentations.

I have spent a great deal of time trying to come up with alternative welfare reform proposals. Earlier this year, I proposed a complete alternative package on welfare reform to try to accomplish certain goals, to try to move people from welfare to work, which I think all of us agree is an appropriate goal, to try to strengthen families, which I think all of us would agree is an appropriate role, and to try to do something about this explosion of children having children.

Any evening, you can go over to Union Station, which is four blocks from where we are now, and watch young girls come in with their own children. And you know that child does not have a chance, or at least that life is weighted against that child.

I want to applaud Rev. Kammer. I have had a chance to deal with the head of Covenant House, Sister Mary Rose, who I have great admiration for. What we need more of in this country is people like her, who actually put their own lives on the line to intercede to help people escape from this downward spiral.

There are a couple of provisions in the proposal by the Governors. I applaud them for the work they have done, but I think it is also true that, frankly, they have a little different interest than we do. You know, these are Federal dollars that we are responsible for. They are responsible for State dollars, and this is very tempting to the Governors. I understand this, and I am not being critical of them, but it is very tempting to replace their own dollars with our dollars and not make much of a difference, other than to their budgets and to ours.

I am very concerned as I look at what they have proposed, that this reduction in maintenance of effort to 75 percent frees up $28

billion for the States to withdraw from their spending, and to substitute with our dollars.

There is a second element of their proposal that would allow States to transfer up to 30 percent of their temporary assistance for needy families to several other programs, including the social services block grants.

That means the States could potentially transfer $30 billion into the social services block grant and supplant State spending on social services. In other words, they would be getting money from the Federal Government. As you can see on this chart, here is $28 billion that is lost because of the maintenance-of-effort changes that they are proposing, $30 billion of loss due to transferability, for a total withdrawal of support of $58 billion.

And I would just like to ask the members of this panel, if I could start with Rev. Kammer and go around and get your responses, does this make sense to you? And what would the impact be in your judgment?

Rev. KAMMER. Well, it does make sense to us. That is the point I made earlier, at least as a Southerner, speaking of my experience in the South, that the States often do this kind of thing.

My State of Louisiana was famous for the ways it gamed the Medicaid system, even after Congress had held hearings on the methods they were using. And then our fear becomes, as we have said repeatedly, that there will be an enormous number of people who will be hurt by this. These dollars mean peoples' lives, their safety and health. And we will be overwhelmed by that need in the communities all across this country.

And the genius of the system as it has existed—with its problems, because we ourselves have called for change—has been that there was a commitment on both parts to care for the poorest families in this country. But many poor families lose in State legislatures when you start putting up social welfare concerns against schools, highways and other kinds of things. And you see this already in the plans brewing in State legislatures right now, to shift that money.

Senator CONRAD. I would just say that I read the story yesterday, I believe in either the New York Times or the Washington Post with respect to what States have already done with their budgets. Some of these Governors have proposed budgets that have already cut back significantly, and they are just waiting for ratification from here.

Mr. Carleson?

Mr. CARLESON. Yes, Senator. I think I am unique on this panel, in that I have run the biggest welfare program in the country, in California back in 1971 and 1972. And later, I was U.S. Commissioner of Welfare, trying to carry this kind of program around to the other States.

In that reform of 1971–72, we saved about $1 billion. In other words, we saved about $1 billion that otherwise would have been spent. But we also raised our basic benefits to the truly needy people. But we made a big savings.

Now at that time, half of those savings were Federal money because whenever we saved a dollar, we saved a Federal dollar.

Now, if I were going to write a bill, I would not make these block grants as big as they are. In other words, there are going to be a lot of savings from elimination of waste that will not be hurting families, will not be hurting children. And they are going to be saving State money and Federal money that they can use on other things.

But we have a bill now. We are getting toward the end of the legislative session. That is why I say, if we have got 100 percent of the Governors that have gotten together on this, it is only for a 7-year period, let us let them have it, and let us get on with welfare reform.

Senator CONRAD. Let me just respond by saying, you know, again I think there is a different interest here—the Governors and those of us who represent Federal taxpayers. Sometimes the block grant starts to look an awful lot like a blank check to this Senator.

I understand the Governors' desire. They would love to have Federal money replace their own so they can shift it some other place. I do not think that is what we are really looking for here. I think if we are able to save money here—which we must—we are going to have to be honest with the American people and honest with ourselves. We have got to save money in these areas, but it ought to be together. If they save some money, we ought to save some money.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Not necessarily disagreeing with Senator Conrad, but to follow up, in my State of Iowa—and I suppose every State is different from another—we have done some adjustment under waiver from the Federal Government, under the Family Support Act, passed in 1988 that said that we were going to move people from welfare to work and save the taxpayers money. It passed overwhelmingly, and was signed by a Republican President Reagan.

Unfortunately, we have more people on welfare. We have not done a very good job of moving people from welfare to work nationally. But in Iowa under the waiver we have 4,000 less people on welfare. We have obviously saved the taxpayers money. Iowa has moved to the highest percentage of people working of any State in the Nation, at 38 percent.

In fact, on signing the contract with the State of Iowa, it is my understanding that of the people that had to come in and sign the contract to continue to receive benefits, 800 people never even showed up. It may have been people who were not aware of what they had to do. Maybe they just fell through the cracks. But it also might indicate that there are some people out there that did not feel that they wanted to be that much out of the underground to be involved in that sort of an obligation.

Well, I want to follow up with you, Rev. Kammer because it is a kind of philosophical question that I need your honest input on.

I guess I assume that we do not have any more compassion here in Washington, and we are elected by the same people as our Governors and State legislatures are. And are you not assuming that we do, and that somehow we are going to be more of a trustee of the poor people than our Governors and State legislators?

And I guess, implied in it, we should not assume that we have more compassion or are more responsive to the people than our Governors and State legislatures are. In fact, I guess I would think that they are closer to the problem and the people and might be even more responsive.

Rev. KAMMER. Senator, I think the problem is posing it as a question of the personal qualities of the people involved in State government or Federal Government. I do not think that is the question.

The question is more a structural question as to which level of government has been able to respond. It may be partly a question of resources. Some of the reason why the South has been so unresponsive has, in some cases, been a lack of resources. And the Federal Government has been able to care about the country at large with the increased resources that you have had.

But the historical record is that it has been the Federal Government since the New Deal, and then again in the 1960's, which in fact has reached out to protect more poor families and to build a safety net underneath this nation's poor.

So I do not think it is a question of impugning the values or the compassion of anybody involved in politics at all. It is a question of what has happened historically. And the record in the States, on AFDC at least, has been a steady decline because, I think, of the competing needs that they have—for example, schools, which you do not have at the Federal level. So it is a question, maybe, of the different levels of Government and their different responsibilities.

But now what we seem to be saying in Congress is that we are going to shift to the States without any guarantee that they can take on this burden, either because they have the resources, or have the will to do so. And that is not clear. It is really not clear. The evidence runs contrary to that.

Senator GRASSLEY. I heard a Governor say that his State got a waiver, and they were able to use the resources to expand the number of people covered under health care so that they only have 6 percent of people who are not covered by basic health insurance plans, whereas the national average is 13, 14, or 15 percent.

Governor Thompson tells us every day he meets with the Republican legislators that we can have a very good plan at the Federal level, geared towards a small segment of the population. Or if we let him handle the money, he will be able to provide basic health care for all the working poor in his State.

We will never do that here in Washington.

Rev. KAMMER. Well, I think we need some controlled experimentation around those questions which the waiver process allows. The fear we have is that we are about to embark on a nationwide experiment involving every poor family in this country which has never been tested.

And this Congress, in the past at least, has generally said let us try something in Utah or South Dakota or Maryland—I do not want to single out any particular State—a few counties here or there, and see if it works.

What we would like to do right now is push poor families off a great precipice into an unknown where nobody knows what will happen. But we have great fears about what it will mean.

Mr. CARLESON. Senator, we just heard him testify that we need controlled experimentation. Now that is our problem—control and experimentation—coming from the waiver process. It is the worst way to run a welfare system. The Governors and the State legislators who are elected are the people who should be making these decision.

The CHAIRMAN. Ms. Stirrup, if I could ask you one question. Your suggestion is to make the Governors' proposals stronger regarding family formation, and reducing illegitimacy. And, of course, I agree with you that efforts to reduce that illegitimacy are critical to welfare reform.

Which of your four recommendations do you think are the most important to our goal?

Ms. STIRRUP. Senator, I would suggest that direction from Washington to the States is essential here because I am just fearful that Governors, if left up to their own, are really not motivated to address this issue head on. That has been evidenced by their recent proposal, which did not address the issue of saving marriage, and trying to reduce out-of-wedlock births.

I guess I would recommend, first of all, to increase funding in abstinence education. I would recommend implementation of the family cap. If it means with an opt-out for States, that would be acceptable to us. And I would advise including vouchers for the care and feeding of children, so that children are not left between the cracks.

I would also recommend that the Federal Government require States to devise their own plans to reduce out-of-wedlock births. I think that the burden should be put on them to affirmatively devise their own plans.

And, fourth, I would recommend changing their suggestion for the reward mechanism. It includes simply those mothers who go to work. I would suggest that the reward mechanism be changed to recognize all means of reducing dependency. They should all be measured equally.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

I also wish to commend this panel for their very thoughtful and helpful insights.

There has been discussion about the fact that we have had in a number of States, including mine of Florida, some waiver authority for demonstration projects in welfare reform. We have very aggressive efforts underway, specifically in the Gainesville area and in Pensacola.

Based on your knowledge of nationwide programs of experimentation on how to effectively move people from welfare to work, and to keep them at work, what principles have we learned from the demonstrations that are underway in the individual States? And how well has the NGA proposal incorporated those best practices?

Dr. DANZIGER. Thank you, Senator. You have made a very important point. Much of the rhetoric acts as if State governments, as soon as they get a block grant, will be able to accomplish results that are much better than the status quo. I don't think that will happen.

As Senator Grassley and you just pointed out, there are program innovations operating under waivers in 30 or 40 States. One of the things we have learned from these programs from non-partisan research and evaluations, is that many States have only been modestly successful in moving welfare recipients into work.

Many people go through the programs. They have a lack in some basic skills. Sometimes those skills are made up; sometimes people get into work first. States are doing a lot of things. One of the most successful programs is the Riverside program in California. It is one of the best programs, yet if one looks 3 years later, less than half of the people who went through the program are working.

It is important that people work. The reason many are not working is that private employers are not looking for a lot of low-skilled labor.

Senator GRAHAM. You say that less than half of those who went through the program are working.

Dr. DANZIGER. It is generally the case that more of those who went through the program are working then those who did not go through the program. One of its reasons fewer participants are working 3 years later is that, when the program ends, they have to face this low-wage labor market. And every day there are reports on the business page about technological change, employers looking to get smart, to use more skilled workers. Welfare recipients have to enter this labor force and are at a disadvantage.

That is why I think, if you are going to cut off the welfare check, you have to have some opportunity for people who are not wanted by the private employers to perform community service so that they can earn their welfare assistance. Government has the responsibility to provide that work-for-your-welfare option.

Senator GRAHAM. Do you think that the Federal Government is one of the levels of government that should be involved in those community service positions?

Dr. DANZIGER. I think the Federal Government has a role, but State or local governments and nonprofit organizations can provide the community service options. I think the mandate ought to be there, but I do not think the Federal Government needs to run those programs.

Senator GRAHAM. Well, in the case of Pensacola, the Federal Government is the principal employer, primarily the Navy. And yet, in their welfare-to-work program, the Federal Government did not participate in any community service. State government agencies did, but not the largest employer.

So should Federal agencies be part of the community service fallback if private employment was not available in the network?

Dr. DANZIGER. I must admit that I have not thought about the issue you raise. I was thinking of things like having welfare recipients work as volunteers in local schools, day care centers, soup kitchens and things like that. However, you raise an issue that should be considered.

Senator GRAHAM. Any other comments? The question is the degree to which the best practices, as they have been demonstrated by these 30 or more States which are engaged in demonstration projects, are embedded in the NGA proposals. Are you satisfied

that this proposal takes advantage of what we have learned through the waiver demonstration at the State level process?

Mr. CARLESON. Senator Graham, back in 1972, as welfare director for the State of California, we applied for a waiver. It was a waiver to have workfare—in other words, require able-bodied recipients to work.

Senator GRAHAM. Excuse me, my time is limited.

Mr. CARLESON. I understand. But what I am saying is that we have been doing this waiver process for at least 25 years since I have been around. We do not need to do the waiver process any more.

Senator GRAHAM. That was not the question. The question I asked was, are we taking advantage of what we have learned——

Mr. CARLESON. Yes.

Senator GRAHAM [continuing]. In this NGA proposal?

Mr. CARLESON. Yes. The Governors are. They are looking at each other's successes, and they are going to improve on each other's successes.

Senator GRAHAM. I would like to ask one other question.

Senator GRAHAM. I was Governor of Florida during the first 6 years of President Reagan's administration. I remember well, at the beginning of his administration, the concept of New Federalism.

Part of the concept of New Federalism was that those income maintenance programs, which included welfare and Medicaid, should be federalized, and that programs such as highways and law enforcement ought to be returned to the States.

The argument for Medicaid was one that differential standards from State to State would tend to induce populations to move to the higher standard States—I think the same argument you have made for welfare.

And second, with Medicaid, you needed to be able to integrate Medicaid with Medicare, particularly since one-third of Medicaid money is spent on the elderly, who also are the target of Medicare.

Now that seemed to me in 1981 to be a persuasive argument for allocation of responsibility between the States and the national Government. What has happened in the intervening 15 years?

Mr. CARLESON. No, Senator, I was in the White House at that time. That was not the Reagan administration's position. That was the National Governors' Association position at that time.

The Reagan administration's position was to block grant AFDC. At one later time, they talked about a swap. They would just repeal the AFDC program, and then have the Federal Government take over the Medicaid program.

But what you are describing was the National Governors' Association position at that time. The Governors' Association now, of course, has a completely different position.

Senator GRAHAM. What has happened in the intervening 15 years that makes that philosophy of Federal/State relationship no longer a rational basis?

Mr. CARLESON. We have a lot of new Governors. [Laughter.]

Rev. KAMMER. Senator, if I may, the point you are making is very well taken. I mean, the two twin programs from the Depression that were the underpinnings of poor families were AFDC and what was called AABD, Aid to the Aged, Blind and Disabled. We federalized AABD in the 1970's as Supplemental Security Income.

From the point of view of the people, that was the best thing that ever happened to most of them, especially in the South. Many people now wonder why we are moving AFDC to the States when, in fact, what we probably should do is federalize it. There would obviously be some major cost questions.

The CHAIRMAN. Senator Moseley-Braun?

Senator MOSELEY-BRAUN. Thank you, Mr. Chairman. I want to thank the panel for the very thoughtful debate and discussion this morning.

I am concerned about the issue of disparate impacts, not just based on race, but also based on geography and by population group.

Looking at my own State of Illinois, our economic numbers, the numbers having to do with unemployment in my State indicate that among white males, the unemployment rate is about 5.9 percent; among white women, the unemployment rate if about 6.3 percent; among black men, the unemployment rate is about 16.6 percent, or almost three times as much; and among black women, 13.6 percent.

But here is the really stunning figure. Among black young people, ages 16 to 19, both male and female, the unemployment rate is 46.2 percent, which is a stunning, stunning figure. It suggests that these young people do not have jobs. And the economy has not been able to absorb or provide any gainful use of their labor.

So the question becomes then, insofar as this welfare debate, is really a debate about what our response to poverty should be.

My question is multi-fold. But the first question is, will we not see a shift of responsibility, not just to the States, but to the localities—the cities primarily—where there are high concentrations of minority poor and a high concentration of these young people, for doing something, caring for the children in the final analysis because that is really where our concern has to start here? Will it be shifted not just to the State but to the localities, the cities, in which they reside?

So what we are looking at is a devolution that not only goes back to the States, but really even to the smaller units inside the States where there are these 46 percent unemployment rates.

So my question becomes, what do we do about the children? And this gets to Senator Moynihan's chart and the whole issue of the cut-off. What about the children? Are we going to face a situation, or promote a situation, in which the cities will be called on to care for the children because the economy will not care for their parents or provide employment for their parents?

And this is my question to the panel. Is there not, in your mind, a national community responsibility to these children that neither the States nor the cities can handle, or should handle, by themselves?

If, for example, the Chairman's State does not have large cities with large populations with 50 percent unemployment among black

youths, but my State does, I believe that the Chairman would be concerned about the youngsters in my State, and what happens with those children.

And so the question is, what about the national responsibility for children in communities in which the unemployment rate among their parents is so atrociously high?

Mr. CARLESON. Senator, you mentioned that the highest unemployment rates were in the ages of 16 to 19. The best thing for those 16- to 19-year-old people is to go to school, and not to be looking for work or looking for jobs.

I know people like to say, well, maybe they could not survive if they did not have the work, but a 16-year-old should be in high school, learning the education that they must have if they are going to succeed and be able to produce money for their children.

So if we are talking about 16 to 19, we should concentrate not on jobs for them; we should concentrate on education for them because that education is what is going to carry them through the rest of their lives.

Senator MOSELEY-BRAUN. Oh, I absolutely agree with you, Mr. Carleson. And I think we have no disagreement about that.

But I guess my question is, with regard to those 16- to 19-year-olds, we are talking about the children that will be affected by what we do here on welfare reform. I use 16 to 19 because there is a group there that are parents of children. That is the issue that you raise, and rightly so.

We have got young people with children, we have the 20-year-old, the 19 and up group to deal with. To the extent that they have children, educational opportunities may or may not be available for them. What do we do about these children? We cannot just wish them away. The children are here and they have to be cared for. The question is, are we going to just require the cities alone to bear this burden without any support from the rest of our National community?

Rev. KAMMER. Senator, this is why I believe that both the cities and the counties have been profoundly concerned about so-called devolution, and why, of course, behind them, the charities and churches have been even more concerned. Because if the cities and counties fail, it comes back to us.

And so there has been profound concern. That is the reason why we believe in entitlement. That is a bad word these days. We say that a guarantee for those poor children has to be preserved in the law.

The CHAIRMAN. I want to thank the panel for your very helpful testimony and answers to the questions.

As I indicated earlier, we will keep the record open until tomorrow at 5:00 p.m. for any further questions.

Senator GRAHAM. Mr. Chairman, in my statement that I presented to the committee, a technical thing. I unfortunately referred to H.R. 1 on page 3 when I meant H.R. 4. I guess I went back 25 years to old H.R. 1, but it should be H.R. 4 in my testimony.

The CHAIRMAN. Very good. Duly noted.

Senator CONRAD. Mr. Chairman, might I ask that a column from the Washington Post of February 26, "Governors Counting Cash Before Reform is Passed," be made part of the record?

The CHAIRMAN. Without objection.

[The article appears in the appendix.]

The CHAIRMAN. Thank you very much. We appreciate your help, and will undoubtedly call upon you further.

Ms. STIRRUP. Thank you.

The CHAIRMAN. I will now call upon the second panel to discuss the NGA proposal for restructuring Medicaid.

This panel consists of Dr. John Goodman, president of the National Center for Policy Analysis; Dr. Robert Reischauer, senior fellow at the Brookings Institution and, of course, our former Director of the Congressional Budget Office; Dr. Louis Rossiter, director of the Office of Health Care Policy and Research at the Virginia Commonwealth University; and finally, James Tallon, Jr., president of the United Hospital Fund and chair of the Kaiser Commission on the Future of Medicaid.

Senator MOYNIHAN. Mr. Chairman, could I take this occasion to extend a special welcome to Jim Tallon, who is a neighbor in upstate New York, a friend, and former Majority Leader of the New York State Assembly?

The CHAIRMAN. Thank you.

Gentlemen, it is indeed a pleasure to have each and every one of you here. We look forward to your testimony.

Dr. Rossiter, we will start with you.

STATEMENT OF LOUIS F. ROSSITER, PH.D., PROFESSOR OF HEALTH ECONOMICS AND DIRECTOR OF THE OFFICE OF HEALTH CARE POLICY AND RESEARCH, VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA

Dr. ROSSITER. Thank you, Mr. Chairman and members of the committee. Thank you for inviting me here today. My remarks are those of a university professor, who has been a very close observer for the last 13 years of the remarkable changes in State Medicaid programs.

I have the honor of successfully competing for grants and contracts from Federal agencies totaling $15 million, and serving as a principal investigator of numerous Federal studies of the role of competition in the financing and delivery of health care.

My research has focused primarily on the Medicare risk contract program, but I was also the principal senior researcher for the study of the cost impact of Medicaid managed care programs in California, Missouri, New York, New Jersey and Minnesota.

These early Medicaid experiments in State flexibility were known as the nationwide Medicaid competition demonstrations.

I am responsible for the research which has led to the oft quoted figure that Medicaid managed care can save approximately 5 to 8 percent for the States.

We also found that Medicaid managed care offers great potential over unbridled fee-for-service for better access to care and improved coordination of care.

In my opinion, you can trace the Governors' requests for flexibility to these early experiments. They were found to achieve many of the goals we all seek for Medicaid—access to care at an affordable price for the most vulnerable in our society. Thus, they were replicated.

The Medicaid competition demonstrations spawned similar managed care contracting programs in virtually every State. At least 11 States have received Federal approval to convert their entire State Medicaid programs to managed care, and cover more uninsured people in the process. Delaware, Florida, Minnesota, Hawaii, Kentucky, Massachusetts, Tennessee, Washington, Oregon, Rhode Island, Vermont, Maryland and California recently received HCFA approval for phasing the bulk of Medicaid recipients in their States into managed care.

This wave of conversion, in my opinion, induces the Governors to come to you at this time and seek unprecedented flexibility in the way they run their programs.

It is as though the States have been operating with a learner's permit since 1983, and now the Governors have voted unanimously to be allowed to drive by themselves.

Perhaps the most important aspect of the Governors' proposal is that it allows the States to move toward new payment systems for care. The Federal Medicaid program was established as a fee-for-service approach to improve financial access to care for low-income people.

Today, fee-for-service is fast declining in the private sector, and is being replaced by more global payment systems. What prepaid payment per person per month accomplishes, that nearly 30 years of fee-for-service Medicaid has not, is to unmask the basic flaws in the current cost-shifting approach to access to care.

A system that permits the costs of care for Medicaid and uninsured people to be merely passed on to other payors is not a system. Allowing the States to redesign Medicaid, with new payments systems largely based on prepaid approaches that suit the local needs and circumstances of the health care market in each State, will unveil the major inequities created by the current system.

We can see vividly how this can work by examining the experience of States such as Tennessee, Minnesota and Oregon.

The States have often been called laboratories. But in this case, the experiments are ready to move from the laboratory to practice. With most States already creating their own managed care contract arrangements, meeting their circumstances and needs, we have reached the point where the studies are completed and the experimental results are in. The answer is that Medicaid managed care can work.

The experience of Medicare, heading now toward 4 million beneficiaries enrolled in HMOs, and the experience to date with enrolling chronically ill groups in managed care plans, shows that it can be done.

States must establish clear quality of care expectations, they must assess the quality, and continuously improve the quality, as we have done in Virginia.

Therefore, I would recommend that, as you review the NGA proposal, you pay particular attention to those and set performance standards for the States.

But the direction for Medicaid is clear. It is time to move forward on this front and give the Governors what they request.

Thank you very much.

The CHAIRMAN. Thank you for a very succinct statement.

Mr. Tallon?

[The prepared statement of Dr. Rossiter appears in the appendix.]

STATEMENT OF JAMES R. TALLON, JR., PRESIDENT, UNITED HOSPITAL FUND, NEW YORK, NY, AND CHAIR, KAISER COMMISSION ON THE FUTURE OF MEDICAID, WASHINGTON, DC

Mr. TALLON. Mr. Chairman, Senator Moynihan, Members of the committee, thank you very much for the opportunity to be here today.

I am Jim Tallon. I am the president of the United Hospital Fund, an independent philanthropy and health services research organization, which has been serving the City of New York for some 117 years.

I am the chair of the Kaiser Commission on the Future of Medicaid, a bipartisan 14-member commission established by the Henry J. Kaiser Family Foundation.

And, as Senator Moynihan indicated, prior to 1993, I served for 19 years as a member of the New York State Assembly, including responsibilities both as chair of its Health Committee and Majority Leader.

With respect to the Medicaid program, and the choices that you face Medicaid exists within the context of the overall health care financing system in the country, a health care financing system in which a large number of people have no health insurance, and a large number of health care providers serving low-income populations use both Medicaid, Medicare and other funds combined to provide service to the uninsured population.

With respect to Medicaid, the population served, the adults and children who make up the bulk of eligibility for the program, are joined by the elderly and the disabled who, while smaller in number, make up the bulk of costs associated with Medicaid expenditures.

Medicaid deals with the complex and costly problems that do not have a home elsewhere in American health care financing, whether it is institutional nursing home care for the elderly, whether it is the care of the seriously mentally ill, mentally retarded, those with complex physical disabilities, or those with serious chronic illnesses such as HIV infection.

The Medicaid program experienced a rapid surge in growth after 1988. The largest factor in that surge of growth were States using provider taxes and donations to draw down, under the Disproportionate Share Program, additional amounts of Federal revenue. Federal law was enacted to curb that surge in growth and, after 1993, projections have returned to historical levels of projections.

As a State legislator, dealing year in and year out with Medicaid budgets, I found that I could deal with the eligibility for the program, the numbers of people to be served and I found that I could deal with the services for which they were eligible. I have grouped both of those in my testimony under "Medicaid as a Safety Net."

I could deal with the price that I paid for the services; and I could deal with the pattern of utilization for the services, a characteristic which in later days has come to be known as managed

care. I grouped that under "State Flexibility" in my written testimony.

Additionally, before you are issues with respect to the standards and procedures to be used to achieve accountability in the program, and finally a series of questions with respect to State and Federal relationships, including fiscal relationships.

With respect to the National Governors' Association proposal—and, obviously, this testimony is based on the six-page memorandum—the Kaiser Commission looks forward to extending its comments as further detail becomes available.

With respect to eligibility, the National Governors' Association proposal is obviously, on the surface, an attempt to compromise. But in its attempt to compromise, it highlights the choices that are to be made in determining who is eligible for the program. Some groups are guaranteed; some groups are not continued with a Federal guarantee; and there are a large number of people for whom there is a lack of clarity, largely because of the definition of disability with respect to future eligibility for the program. In most cases the alternative to eligibility for the Medicaid program is no insurance.

Second, there is within the Governors' proposal an elimination, at least in part, of an existing Federal commitment to expanded coverage of children and a partial reduction of existing provisions with respect to cost sharing for low-income Medicare beneficiaries.

And finally, with respect to eligibility, the ultimate impact of costs associated with this program will hinge largely on the definitions of disability that are adopted among the 50 States, clearly moving in the direction of a much wider variation of those definitions than the existing program.

With respect to services, there is already significant variation among the States, but the Governors seek virtually complete flexibility on the definition of services, and with price the proposal contains similar pattern of seeking complete flexibility.

The problem is simply that in order to work, Medicaid must combine eligibility, services and price that meet the patient's needs, all at the same point in time. If there is skepticism with respect to the question of reduced or eliminated standards, it is based on the complexity of the task of bringing together eligibility, services and price at the same point in time.

With respect to the fourth variable, the pattern of use or managed care, we have virtually no experience in converting the disabled and elderly populations on Medicaid to managed care programs. I am an advocate of managed care, and sponsored legislation in New York as a legislator. Thirty percent of Medicaid beneficiaries are now covered under managed care.

Second, States begin from a very different position with respect to their current provider and payment patterns.

And finally, most States, including my own of New York, which have attempted large-scale conversions of the Medicaid population to managed care, have run into difficulties with respect to both marketing practices, availability of services and, in some cases, insolvency of plans.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Dr. Reischauer, it is a pleasure to have you back.

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

STATEMENT OF ROBERT D. REISCHAUER, PH.D., SENIOR FELLOW, THE BROOKINGS INSTITUTION, WASHINGTON, DC

Dr. REISCHAUER. Thank you, Mr. Chairman. It is a pleasure to have this opportunity to discuss these issues with you.

At the outset, I would like to commend the National Governors' Association for their constructive attempt to fashion a bipartisan compromise in this highly charged area of public policy.

Even though the details of the National Governors' Association plan have yet to be specified, I think there are a number of aspects of this plan that should raise concerns for policymakers. And I want to touch on just four of these.

The first of them is the fact that the Governors' proposal would eliminate guaranteed Medicaid coverage for certain vulnerable populations that currently have such protection, including poor children between the ages of 13 and 18, who will be phased into the Medicaid program over the next 6 years, certain disabled recipients and certain recipients of AFDC.

While some States might choose to continue to cover some of these groups, there is going to be no financial incentive for them to do so, with the exception of certain elderly and disabled participants. And that is because the Federal payment that they receive through Medicaid will not vary depending on how many of such individuals the State chooses to cover.

At a time when economic, demographic and social forces are pushing up the number of Americans who lack private health insurance coverage, we should not be reducing the mandatory coverage extended by our public programs.

The second area that I have concern about is the complete flexibility that the Governors' plan would give to define the amount, duration and scope of services provided to guaranteed populations. This could, in extreme circumstances, lead to situations in which people who are guaranteed coverage are really guaranteed nothing at all or given a very skeletal package of benefits.

I think there is need for some increase in flexibility with respect to service standards. But at the same time, I think some minimum Federal standards really have to be maintained.

On a related matter, the Governors' plan could eviscerate the Medicaid protection provided to qualified Medicare beneficiaries by reducing the coinsurance that Medicaid now makes on behalf of these individuals. This arises, of course, because States, under the Governors; plan would be free to substitute Medicaid payment rates for Medicare payment rates when they determine how much coinsurance they are liable to pay.

What this means is that families could find themselves faced with large, out-of-pocket expenditures which they are not required to meet today. Even if providers were required to accept Medicaid rates as payment in full, you would get a situation in which some providers would stop serving these populations, thereby reducing their access to care, rather than increasing their out-of-pocket costs.

The third area of concern that I have with the Governors' proposal is the fact that, because of a number of modifications proposed by the Governors in the current program, this proposal would allow States to reduce their effort on behalf of Medicaid disproportionately relative to the Federal cutbacks.

By disproportionately I mean that if the Federal Government was cutting back its effort by, let us say, 12 percent, States would be free to cut back their effort by even more than 12 percent.

This comes about through three modifications that the Governors have put forward. The first of these is the special grants that would be given to certain States for services provided to Native Americans and illegal aliens, which would not have to be matched, unlike current Medicaid spending.

The second is the increase from 50 to 60 percent in the minimum Federal matching rate that is called for which would allow roughly half of the States to reduce their own effort without reducing the amount of money that they would receive from the Federal Government. If States took full advantage of this—which I would not expect them to do—you would see a very substantial reduction in total Medicaid spending by State governments.

The third modification is, of course, the reinstitution of the provider tax and donation schemes. Under the Governors' proposal, this would not lead to the problem that we had back in the late 1980's and early 1990's where the Federal Treasury was basically ripped off by State actions. But it would allow the States the flexibility to reduce their own contributions to Medicaid without affecting the amount they receive from the Federal Government.

In short, the Governors' proposal provides States with disproportionately large shares of the fiscal relief that would arise from restructuring Medicaid. I think that if we look at the relative strength of State budgets versus the Federal budget right now, that split is inappropriate.

Fourth and finally, I think the Governors' plan does not provide the protection that it thinks it does for States from unexpected increases in program costs.

The insurance umbrella that is proposed would provide some protection from short-duration increases in caseloads and initial protection from long-run increases in caseloads, but over time the latter would be built into the basic distribution formula, and it would not benefit States. Nor would there be any protection from secular increases in medical costs that were unexpected. So I think that some adjustments have to be made to the umbrella policy.

Thank you.

The CHAIRMAN. Thank you.

Dr. Goodman?

[The prepared statement of Dr. Reischauer appears in the appendix.]

STATEMENT OF JOHN C. GOODMAN, PH.D., PRESIDENT, NATIONAL CENTER FOR POLICY ANALYSIS, DALLAS, TX

Dr. GOODMAN. Thank you, Mr. Chairman, members of the committee.

My name is John Goodman. I am president of the National Center for Policy Analysis. And I would like to make six brief points.

First, Medicaid spending has been growing at an unsustainable rate, creating not only a direct burden for taxpayers, which has tripled since 1988, but also an indirect burden to rising medical prices. Our own model concludes that the primary reason for rising health care costs over the last 30 years is the expansion of Government health care programs, primarily Medicaid and Medicare.

And our own model, as well as HCFA studies, confirms that each additional dollar that enters the medical marketplace from these programs buys about 57 cents in higher prices and 43 cents in real services.

Number two, there are understandable reasons why Medicaid costs are exploding. Patients and providers face perverse incentives, and they respond to them. It took the Chicago Tribune very little time to go out and locate an individual who in 1 year made 426 visits to 11 doctors, despite the absence of any real evidence of any illness, and he collected 65,000 pills, 20,000 syringes and 343 bronchial inhalers, all of which have a street value in Chicago. And although this was an extreme case, it was by no means unique.

At the same time, the States have been hampered in their ability to adopt proven, well-known cost control techniques that work in private industry, such as managed care and medical savings accounts.

Number three, the problem is made worse by the fact that the States have weak incentives to eliminate these kinds of wastes. The average State is to keep only 43 cents of each dollar of waste it eliminates. And in some States, that number is as little as 22 cents.

Point number four, the ideal solution would be to block grant Medicaid, along with all other Federal means-tested poverty programs to the States with very few strings attached, nothing more than the requirement that the money be spent to help people in poverty.

We are spending an enormous amount of money on Federal means-tested programs today—by one estimate, $350 billion a year. That is $9,000 per poor person, or $36,000 for a family of four. But the problem is that this money currently flows through more than 300 separate programs.

Yet poverty does not come in neat compartments. There is not a food problem that is separate from a shelter problem and a Medicaid problem. All these problems are interrelated. And it is for that reason that local communities really need access to the entire pool of money, and they need the flexibility and freedom to spend the money in ways that help people the most and give the greatest rate of return.

Number five, although the solution proposed by the Governors stopped short of what I consider the ideal, it is nonetheless a major step in the right direction. We estimate that if the States took full advantage of new opportunities that would be created by this proposal, implementing managed care, medical savings accounts, managed care combined with medical savings accounts and other reforms, we should be able to save $170 billion over the next 7 years, which more than meets the budget targets.

Number six, because the Governors' proposal is subject to different interpretations in places, I would like to caution that it is important in implementing it that we do not create new restrictions and new burdens for highly successful experiments that are now underway at the State level.

The Oregon workfare program, for example, is apparently the best workfare program in the country. It needs to be continued. The Oregon health care program is the first example anywhere in the world that I know of where government has actually said they only have limited health care dollars, and invited all the voters and members of the community to participate in deciding how to create priorities for the spending of those health care dollars.

Additionally, under some Medicaid pilot projects, there is experimentation with medical savings accounts and other cost control techniques. All of this needs to continue. Therefore, in making one kind of reform, it is important that we not close doors to other kinds of reform.

In conclusion, Mr. Chairman, I would like to say that Medicaid reform is possible and desirable. And the Governors' plan is a step in the right direction.

Thank you.

The CHAIRMAN. Thank you, Dr. Goodman.

[The prepared statement of Dr. Goodman appears in the appendix.]

The CHAIRMAN. Over the course of our hearings, there has been a great deal of concern expressed about the NGA proposal, that States will shift significant costs to the Federal Government.

So I would like to have each of you comment on these areas. I will start out with two.

First, as States are allowed to define who is disabled, do we need to provide a threshold or range within which the State could extend coverage? Some contend that the States will cover too few people; others believe that the States will shift costs to the Federal Government.

My second question is with respect to the issue of provider taxes and donations which has been raised, and on which one or more of you have commented today. Do you see the past experience being repeated, or has the incentive to leverage Federal resources been mitigated?

Dr. Rossiter?

Dr. ROSSITER. On the first point, it would seem to me that the NGA proposal, as both an aggregate amount that is offered to States for their Medicaid programs, and also tied to a formula, provides enough incentives for them to maintain their level of effort.

It would be very interesting to me, Mr. Chairman, to ask the Congressional Research Service or the Congressional Budget Office to examine today the current optional benefits and optional eligibility categories that are available today to the States that they could cut today. They would lose their Federal match, yes, but they would also save State dollars as people are concerned about with this proposal.

And they could identify those current optional eligibility categories and services, and how much they could cut back today. And my hunch is that it is probably quite large and quite remarkable.

And it is hard for me, when I look at States like Oregon, Tennessee, Washington, Minnesota, and others, who seem to be talking more about expanding coverage, eliminating the cost shifting in their States, to imagine that with the modifications the Governors are proposing that there would be an immediate run towards cutting their payments.

The CHAIRMAN. Mr. Tallon?

Mr. TALLON. Mr. Chairman, the issue with respect to fiscal incentives for the States in relation to the Federal Government is the most current iteration of a long-standing debate about the appropriate allocation of Federal funds to the States under this program, a debate and a discussion that has rich history. There have been criticisms made of the current matching formula as it is associated with per capita income. Proposals have come forth from time to time.

The difficulty of achieving a redistribution among the States, as Senator Moynihan has indicated on many, many occasions, brings to this proposal a discussion of how to deal with the question of some States believing that they have been over the years required simply to carry too large a share of the burden. So this is within the context of a long-standing debate about the appropriate allocation among the States and the appropriate relationship between the Federal Government and the States.

Certainly as a New Yorker, and certainly as a legislator in New York, I feel the difficulty of my former colleagues and the Governor of New York, who are now dealing with a significant budget gap on this issue.

With respect to your specific question on whether the definition of disability creates an incentive to shift to the Federal Government, I do not believe it creates that in and of itself.

On incentives to shift responsibility to the Federal Government, the risk with respect to the broad flexibility in defining disability is largely, I believe, with respect to the patients themselves who fall into those various categories.

Disability covers a wide range of potential circumstances, and dramatic State by State variation is going to place some patients at risk, and it may even result in risk being shifted among the States as States achieve different definitions of disability.

With respect to your final question, sir, on the provider taxes and donations, I do not believe that the Federal Government is as much at risk with respect to the proposed redefinitions on provider taxes. I think the people who are most at risk are the providers of health care services themselves who potentially, as I read the Governors' proposal, would be at risk of being burdened as the source that would be used to raise the State share, in effect removing dollars on a net basis from the health care system, directly from the providers and, of course, ultimately from the patients they serve.

The CHAIRMAN. Dr. Reischauer?

Dr. REISCHAUER. I agree completely with Mr. Tallon on the second answer, that the Federal Treasury really is not at risk for a drain, but the States will be allowed to reduce their effort significantly, and that will play back on less for either providers or beneficiaries.

With respect to your first question, which had to do with should we have minimum national definitions for disability, or maybe maximum ones as well, I think the answer is definitely yes with respect to minimums; maximums I am not particularly concerned about in a structure like the National Governors' Association proposal because the amount of Federal liability is more or less limited. And in any case, it would be a reduced incentive on their part, relative to the current system.

With respect to just the structure of our existing Medicaid grant system, what we have to keep in mind is that right now we are saying to States that we will allow you to provide a service, health care for low income populations, at sale prices. You will only have to spend 50 cents to as low as 20 cents to get a dollar's worth of this activity.

And so they purchase a certain amount of it when they trade off prison services or educational services versus health care for the poor. They are facing a different set of State prices for a dollar's worth of services.

Proposals like the Governors' proposals or the Medigrant proposals raise that price at the margin very considerably to States. They raise it to a dollar. If you want a dollar more of services, the State has to put up that dollar. So, you know, it is quite simple. States will, not because they are mean, but because their incentive structure has changed, cut back on the amount of the service that they buy. And, you know, this is sort of an economic fact. Now it might be a little or it might be a lot, but the direction is clear.

The CHAIRMAN. Thank you.

Dr. Goodman?

Dr. GOODMAN. I am concerned about turning over programs piecemeal to the States, turning over some but not others. I think we should adopt the Governors' proposal but remember that you leave the States with incentives to shovel people into those program where they get the highest match from the Federal Government, and away from those programs that are either block granted or where the funds are capped in some way.

After the disabled, I think we simply have to come to grips with the fact that there is an unlimited amount of money that we can usefully spend on health care. We could spend the entire gross national product in useful ways on health care. Therefore, one of the things we must do is establish priorities and make choices.

Senator Moynihan, you are looking at me very puzzled. I mean it is really true. We can spend that much. And it seems to me that priorities need to be set at the local level where people live.

Senator MOYNIHAN. I was puzzled because I was surprised that someone would say something so obvious.

Dr. GOODMAN. All right. Thank you.

That is all I have to say.

The CHAIRMAN. Senator Moynihan?

Thank you, Dr. Goodman.

Senator MOYNIHAN. Could I ask this distinguished panel to address a subject which concerned this committee in the last Congress, when we were taking up the whole question of a universal health care system that President Clinton had proposed?

We began—not each of us necessarily—but we began with the understanding that health care costs were going up and up and up, and up and up. And then we began to hear that, no, as a matter of fact they are moderating. They are rising, but not necessarily escalating the way they had been. And this was indeed in response to health maintenance organizations and price competition, and some kinds of rationing.

And I know that for my part, early on, I asked Paul Parks, M.D., president of Sloan-Kettering Cancer Center in New York, if he would organize a "seminar" for me on health care issues to inform me on this subject. And he brought some deans in from around the country. We started about 10 a.m., and one dean said, "You know," referring to one of those States where they do everything right, the Nordic tier up there, he said, naming one of the States, "they may have to close their medical school." I said, "What?" He said, "Well, the HMOs are now enrolling an increasing proportion of the population." HMOs seem to move from West to East, a rather different variation. And he added, "With more and more persons in HMOs, patients do not get sent to teaching hospitals. If you do not have a teaching hospital, you cannot have a medical school."

At that point, I realized that I had learned something new. I had finally heard something about medical schools that I had not heard before.

Before we finished our legislation, the Finance Committee had imposed a tax on all health care policies to provide a trust fund for medical schools, teaching hospitals and medical research. Senator Hatfield was interested in the latter. And it came out of this committee very nicely, but in the end, nothing happened.

What would you predict the effect of the Governors' proposal would be on who is going to pay for the medical schools and teaching hospitals? This is something we have not yet addressed. Mr. Archer is interested in it. Will this not make that situation more difficult? Without a view, I would just like to ask Dr. Rossiter.

Dr. ROSSITER. Thank you, Senator Moynihan. I wanted to say that it is an honor for me to be here to appear for you today. Having read much of what you have written over the last 30 years, I have appreciated your stand on many issues.

I chair the graduate medical education funding task force in the State of Virginia under a Robert Wood Johnson generalist initiative funding grant. And we are grappling with this today. We have three medical schools in Virginia, and I just cannot believe that in any other State it is not equally true, these are the jewels of health care in each State. And the public attitude toward these institutions of medical education is very warm and supportive.

I would think that any Governor that threatened immense cuts and did not pay particular attention to their medical schools would be in big trouble. Perhaps no one can speak to that point.

Senator MOYNIHAN. But would the spread of HMOs exacerbate a problem? Has Medicaid become a source of funding that we did not necessarily intend, but may have had this effect?

Dr. ROSSITER. It has been a very important source of funding. All of the schools, and particularly the public institutions, are quite beleaguered today as they see their patients pour out of the hospital.

But I think they are learning that the times are changing, and they have to do things differently.

And that is why they are turning attention toward increased training of generalist physicians. They are changing the way the curriculum is taught. But I think for this particular proposal, for the NGA proposal, there has to be some attention paid to the way disproportionate share hospital payments are paid. And perhaps guidelines could be developed or there could be certain expectations on the part of the States to be careful that the funds are used to protect these institutions.

I understand that Tennessee recently reached agreement with HCFA to pay a per-resident amount for disproportionate share. There are others that have certain requirements for disproportionate share that it be used toward primary care payments as well. But it is clear that the handwriting is on the wall. We must move away from the hospital-based approach that is represented by these payments.

Senator MOYNIHAN. Perhaps I could ask for written comments from the other members of the panel, Mr. Chairman.

Dr. GOODMAN. May I say something? I think we are in danger of missing the forest for the trees here. The market is becoming very, very competitive. HMOs are helping make it competitive.

Senator MOYNIHAN. Yes.

Dr. GOODMAN. But it is going to become very competitive anyway. In a competitive market, you cannot shift costs. So that means that all subsidies have to be direct. So we are going to have to change the way we pay for teaching hospitals.

Senator MOYNIHAN. But that is what the committee judged when we decided to have a trust fund. We would have a tax for this purpose.

Mr. Tallon?

Mr. TALLON. Senator Moynihan, I believe the answer to your question is that it could be a problem. And it is against that possibility that the Governors' proposal that seeks maximum flexibility, complete flexibility with respect to setting its price structure, substantial flexibility, complete flexibility in designing its managed care programs. This is the issue with which you are grappling with here.

In the Medicaid program in New York, for example, as of January 1, 1996, in payments to managed care plans, monies have been set aside for direct payment of medical education costs of hospitals serving those patients, and the money flows directly to the hospitals. In other States that have converted to managed care, there has been some move away from the teaching hospitals that have supported that enterprise.

With respect to the Medicare debate, which is under the jurisdiction of this committee, you have debated extensively how to deal with direct and indirect medical education, including the debate about whether or not those payments would be mandated to be in HMO rates or would be set aside into separate funds.

So the issue is that it could be a problem. The answer is that there are remedies to resolve that problem, and they all go to the question of what standards will be adopted in whatever legislation you consider.

Senator MOYNIHAN. Dr. Reischauer?

Dr. REISCHAUER. I think it is highly likely that under proposals like the National Governors' proposal, the volume of Medicaid patients going to teaching hospitals will fall.

It is true that in almost all States right now the Medicaid patients going to teaching hospitals do not pay their full costs. Somebody else picks it up somewhere. So in a strict financial sense, the teaching hospital might not be worse off. But at the same time, it would suggest that we would have tremendous overcapacity in teaching hospitals, and they would have to shrink. So if you want to maintain the capacity, you have to find some direct form of subsidization, as Dr. Goodman suggested.

Senator MOYNIHAN. I thank you very much, gentlemen. All four of the responses were very helpful. I think it is an issue we have to address.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. I would like the panel to respond to this question. If the States define who is disabled—under the National Governors' Association, that is the approach—I think we can assume it is clear that some of the disabled who are currently listed as disabled will not be qualified as disabled under the new definitions.

Now it is also clear, I think, that under the proposition of prior existing condition, they cannot get private insurance. Now what is going to happen to those folks?

Mr. TALLON. Sir, if I may start?

Senator CHAFEE. I have you in my eyesight here.

Mr. TALLON. Thank you, Senator.

Senator CHAFEE. Never look up is something I learned in law school. [Laughter.]

You establish eye contact.

Mr. TALLON. Sometimes, Senator, you want to get called on.

Senator, in my comments, and in my written testimony, I think that goes to the core of the issue, that the people most at risk in this question of giving broad definition of disability are the people who are disabled themselves because I do not see any other home in the American health care financing system that is ready to take on that degree of responsibility.

And as we look across this broad definition of disabling conditions and recognize what is there—serious mental illness is there; mental retardation is there; complex physical disability is there; a whole series of chronic illnesses are there, of which HIV infection is perhaps the most recent manifestation; and there are then, subject to varying views of a debate, issues of substance abuse involved in disability definitions.

Among all of those people, whether it is private health insurance, whether it is Medicare, perhaps in the final analysis the place where responsibility, absent Medicaid, would fall for these individuals would be whatever publicly operated safety net would continue to reside under direct State or local responsibility in the States.

Senator CHAFEE. I am not sure what that is.

Mr. TALLON. Well, that is true, sir. And of course, as you recognize, that is being diminished by States and municipalities.

Senator CHAFEE. Now I am going to try Dr. Goodman, who I presume has a different answer, I suspect.

Dr. GOODMAN. Well, I think this one of the areas where there is no objective line that can be drawn, where you can say the person on one side deserves help from taxpayers; the person on the other side does not.

And since there is no objective line that can be drawn, where it is going to be drawn depends on the opinions of people and their values. So those are precisely the kind of questions that seem to me should be settled at the local level.

And the role of Congress is to ensure that a reasonable amount of money is spent taking care of people who need help. But the priorities need to be set locally.

Senator CHAFEE. You said, if I have got it written down here correctly, that the States only get to keep 43 percent of the total Medicaid dollars they save.

I was not quite clear why it worked out that way because it seems to me that they get 100 percent of the State savings. How do you arrive at 43 percent?

Dr. GOODMAN. On the current matching system, or under any matching system, as Bob Carleson testified in the first panel, that is the problem with the whole matching system. If you cut out waste, the Federal Government takes half the savings.

Under the Medicaid program, you save a dollar of waste, the State gets 43 cents and the Federal Government gets 57 cents. Some States are only putting up 22 cents of their own money. So if they cut out a dollar of waste, they save 22 cents for themselves and 88 cents for the Federal Government.

Senator CHAFEE. I see.

Dr. GOODMAN. Conversely, if they do something that causes waste, the Federal Government pays 88 percent of it, they pay only 22. That is a terrible situation.

Senator CHAFEE. Are you looking at this from a point of view of incentives, or of the fact that they should get more money back than the 22 or 43, or whatever the percentage is?

Dr. GOODMAN. I am saying that those are the current incentives. Under an ideal incentive system, if they cut out a dollar of waste, they should get to save the dollar.

Senator CHAFEE. Yes, that is a heads I win, tails you lose proposition, is it not? If they spend more, they only have to spend 27 cents. If they save something, they should get more than the 27 cents, if you are Mississippi.

Dr. REISCHAUER. There are two components to spending—wasteful spending and useful spending.

Senator CHAFEE. Yes.

Dr. REISCHAUER. And we treat them both with the same matching rate. And if the useful spending is going to be matched or shared by the Federal Government, then inevitably the unuseful is too. There is no way around that problem.

Senator CHAFEE. Yes. I am just not sure. Dr. Goodman, is your point that, therefore, you lose an incentive? Let us say that Rhode Island's matching share is 43 percent, 43 percent and the Federal Government 57 percent for every Medicaid dollar.

Now what you are saying is that under the current system, if Rhode Island makes some savings through managed care, whatever it might be, they only get 43 cents?

Dr. GOODMAN. That is right.

Senator CHAFEE. Well, how much to you want them to get?

Dr. GOODMAN. Well, if you want them to have good incentives, you set it up so that when they save a dollar they get to keep the dollar. And you do that to a block grant or by a form of a cap to the amount of money they have. But you do it by getting away from that one-to-one match.

Senator CHAFEE. Well, then I think you are also going to have the same rule on the upside. If they spend an additional dollar, you would have them pay the whole dollar?

Dr. GOODMAN. That is right.

Senator CHAFEE. All right. Thank you.

The CHAIRMAN. Senator Conrad?

Senator CONRAD. Mr. Tallon or Dr. Reischauer, is there anything Dr. Goodman said there that you would disagree with or that you would want to comment on?

Mr. TALLON. The only comment that I would make is that in essence, as you move from the matching system to the proposal that is before you, you are being asked to increase the Federal share. And then, of course, the States are at risk with respect to it. As long as they stay within wherever the minimum match is, the State is either going to have the cost or the benefit associated with additional spending.

The issue beyond that, of course, is for putting up that Federal share and for appropriating what I believe will grow under the proposal to more than 60 percent of the total program costs, what criteria do you want to adopt in return for that payment of more than 60 percent of the total program costs? Part of this is matching, but the issue is what does the Federal Government get for the Federal resource that is here?

And in the proposal that comes from the Governors, there is a broadening or, some would argue, a weakening of the statutory standards. There is a diminution of the executive or administrative role at the Federal level and there is a constraint on the actions of the Federal Judiciary.

So the issue here of Federal/State responsibility really goes to the question of what does the Federal Government expect for the Federal money that comes into the program?

Senator CONRAD. Let me just say that, as one Member here, I am really troubled with the principle of separating the responsibility for raising money and the responsibility for spending it. I just think, as a first principle, there is something troubling in that.

If I could go to a couple of specific examples, this is what is happening in the real world. This is an example from Michigan. In October of 1993, Michigan paid $489 million to the one hospital that met its new DSH definition. It changed DSH definitions. It happened to be the State-owned University of Michigan hospital. The State claimed $276 million in Federal matching funds for this payment. But the public hospital returned the full $489 million payment to the State through an intergovernmental transfer, the very same day the Federal payment was made. Now that is a good deal.

Through this one transaction, Michigan realized a net gain of $276 million in Federal Medicaid payments without expending any State funds. That is one example. For those of us who have been

talking repeatedly about the chance to substitute Federal money for State money, or the chance for the State at least to dramatically reduce what it is doing, these examples I think ought to be sobering.

Let me give you another example from Michigan. I do not mean to pick on Michigan; it just happens I have got these examples. In fiscal 1993, Michigan raised $452 million through hospital donations, and then paid the hospitals $458 million in disproportionate share payments. In other words, they took from them with one hand and turned around and gave it right back with the other. Based on these payments, Michigan claimed $256 million in Federal matching funds.

The net effect of these transactions is as follows: The hospitals gained $6 million, $458 million in DSH funds, less $452 million in provider donations. So the hospitals were ahead $6 million. The State gained $250 million, $256 million in Federal matching funds, less $6 million in net payments to the hospitals. So the State was the big winner here. And the Federal Government, old Uncle Sugar, what a sucker! The Federal Government paid $256 million in Federal matching funds without any net State funds having been expended.

Now that same kind of scheme could go on under the Governors' proposal.

Now, Dr. Reischauer, you are shaking your head and saying no.

Dr. REISCHAUER. No. It cannot because, if the State did that, it would not get any more money from the block grants so the Federal Treasury would not be at risk. But what it could do with a scheme like this is simply free up State monies with, in a sense, sham matching that it could spend on education or some other State activity.

Senator CONRAD. Yes, that is really the point I wanted to make. They could do this same kind of sham transaction. The result would be that they would reduce what the State had to put up.

Dr. REISCHAUER. Right. For the constant amount of Federal grant money.

Senator CONRAD. As I tried to analyze in total what this could lead to, I am told that if we took the $85 billion of Federal reduction, that you could anticipate as much as $200 billion of State reduction in effort.

Dr. Reischauer, is that correct?

Dr. REISCHAUER. I think that kind of number, in that ball park, also includes States reducing their effort because the Federal matching minimum would be raised from 50 to 60 percent.

Senator CONRAD. That is correct.

Dr. REISCHAUER. And it would thus relieve the bulk of what would go on there.

Senator CONRAD. That is correct. That is in the other way going from 50 to 40 on the match, kind of the reverse effect.

From the States' perspective, if that were to occur, that would be a reduction of some 26 percent in Medicaid in the final year of the plan. What would be the result of that? Is there any way that you could be providing services so that vulnerable populations would not be hurt under that scenario, in your judgment?

Dr. REISCHAUER. In my judgment, no. Certainly, some would come from improved efficiencies, the ending of or reduction in waste. But there is no way to extract resources of that magnitude without doing one of several things, and probably a bit of all.

One, reducing the number of beneficiaries from what the number would otherwise be; two, reducing the quality or quantity of services that the average beneficiary receives or; three, reducing the payments that are made to providers. And in many cases, those reductions in payments would be made up by some other entity, through some kind of cost shifting, although that is much less possible now than it was several years ago.

But there are going to be real impacts, and the real impacts are going to be ugly.

Senator CONRAD. If I could just thank the Chairman and Ranking Member. I think the panels today have just been excellent, and I think the Chairman and Ranking Member should be thanked for the quality of the witnesses we have had.

The CHAIRMAN. Very good.

Senator Graham?

Senator GRAHAM. Mr. Chairman, I would like to concur in the comment that was just made by Senator Conrad. And I would also like to commend this panel, as I did the previous one, for their very thoughtful analysis of these difficult issues.

I would like to ask two basic areas of questions. The first has to do with the impact of Medicaid reforms on older Americans. Approximately one-third of all Medicaid expenditures today are on persons over the age of 65, and that is a growing percentage.

We know certain things about the over-65-year-old population in America: One, it is growing, both absolutely and as a percentage of the total population; second, part of that growth is that people are living longer, so we are dealing with an aging process as opposed to a single cataclysmic event; and, as Secretary Shalala indicated yesterday, as more elderly live into advanced ages, there is a greater aspect of poverty among the elderly as they utilize their saved resources.

In responding to a question yesterday that I asked of the Secretary, as to how Medicaid should be modified to deal with these realities of our aging population, she suggested two things. One, that there should be an increasing integration of Medicaid and Medicare and, second, that there should be greater attempts to use managed care for the elderly.

I wonder if you could comment on those two recommendations of the Secretary and any other ideas you might have as to Medicaid reform as it relates to older Americans.

Dr. ROSSITER. Those are excellent suggestions. And I think perhaps the NGA proposal gives the States the flexibility they need for their Medicaid programs to wrap around the Medicare program.

If Medicare stays as it is, it has the option for risk contracts. As you know, Senator, in your State there are many tens of thousands of Medicare beneficiaries enrolled in Medicare HMOs. And this would enable Medicaid agencies in each State to figure out the best ways to add the Medicaid portion to Medicare enrollment.

And if we move forward with provider service networks that would perhaps expand the options for the elderly, this proposal

would be all the more important to give flexibility to Medicaid instead of trying to have two programs that are not quite the same, and do not meet the local needs and circumstances on the Medicaid side.

Senator GRAHAM. Mr. Tallon?

Mr. TALLON. Senator, with respect to the Medicaid program, recognize that the elderly who are being served here are in one sense poor elderly people, and Medicaid is helping to pay their cost-sharing provisions under the Medicare program. And that is important. In the Governors' proposal, there is some weakening of that commitment over time.

But recognize further that many of the elderly using the Medicaid program are very sick people, and they are people who are by and large institutionalized. Therefore, because they do not represent the total distribution of the elderly population, and because their circumstances require extensive and, in some cases, very costly and intensive services, there are limits to how much managed care can do with respect to the elderly specifically being served by the Medicaid program.

In a practical sense, our dilemma is that we do not have a lot of experience in this area. Clearly, if there is a solution to be found, that can provide good services and ultimately constrain growth in costs over time, in my view it is to be found in integrating the services under the Medicare and Medicaid programs.

Obviously, if you look into the Medicare Part A expenditures, you will find that even though the slice is relatively small, the most rapid rates of growth in Medicare in the past couple of years have been in home care services and nursing home care services. That is a positive direction in the program.

But I am not sure that it gets to the core of why and how we are spending money for Medicaid for elderly people.

Senator GRAHAM. I apologize, but I want to be able to ask my second question. So I will submit that question to each of you for written response, if you would.

[The answers appear in the appendix.]

Senator GRAHAM. My second question goes to the comment of Dr. Goodman about the fact that there has been an explosion in the cost of Medicaid to the Federal Government and to the States.

Looking behind why there has been an explosion in costs, I think there are some key factors. One we just talked about, and that is the increasing number of older Americans who are utilizing the Medicaid system for some of the most expensive services which are financed under Medicaid.

Second, we have also talked about DSH payments, which today represent approximately 14 percent of total Federal Medicaid payments.

Third, the decline in the number of persons covered by private employer-based insurance and the almost commensurate increase—particularly in poor children covered by Medicaid.

And there have been policy initiatives taken by a number of States in the South. There has been a major initiative in the last decade against infant mortality. It has been primarily financed by increasing the number of persons served through Medicaid.

If those are some of the fundamental reasons why there has been this explosion in costs, do you agree that these are basic reasons; and how, in your opinion, does the Governors' proposal relate to those underlying causes for increased cost?

Dr. Reischauer, you did not get a chance to answer the first question.

Dr. REISCHAUER. Well, those are certainly among the more important of the reasons for the increase in costs. The Governors' proposal, of course, gets to this simply by creating a more or less fixed budget for Medicaid. And the States will have to cope as best they can with a constrained amount of resources.

Should there be unexpected demographic developments or a surge in expensive medical technology that pushes up costs, quite frankly they would have little recourse. They could go to their own taxpayers for added money for this, or they could reduce the relative quality of the care they are providing.

Senator GRAHAM. For instance, should there be some component to try to deal with the issue?

Dr. REISCHAUER. Oh, I think there definitely should. Unlike Dr. Goodman, I think that the basic amount that the Federal Government provides should vary with underlying conditions.

In the Governors' proposal, the size of the basic block grant should vary according to the size of the caseload of mandatory individuals.

Dr. GOODMAN. It does.

Dr. REISCHAUER. No, it does not. But we can talk about this later.

And with medical costs, legislation should write into it what the assumed rates of growth of the caseload and the assumed medical cost increases are. And to the extent that, in actual situations, we see deviations from that up or down, the size of the block grant should vary up and down.

Senator GRAHAM. Could Dr. Goodman respond?

Dr. GOODMAN. Well, my reading was that there would be a formula that would allow for increases in the population that is to be served. The proposal is a bit vague on exactly how it would be written, but the way I read it, the State would get its funds. It does not get more funds if it spends more money, but it gets funds based upon a reasonable estimate of the population to be served.

Whatever that population is, the real question to be asked of Medicaid, and Medicare as well, is why are these programs not controlling their costs as successfully as employers appear to be controlling costs around the country? I think the answer is because their hands have been tied.

Senator GRAHAM. Your information is that Medicaid has had a significantly higher per-capita-served cost, and particularly cost increase, than has other areas of health coverage, specifically privately or insurance-financed health care?

Dr. GOODMAN. I think so.

The CHAIRMAN. We have a vote on, so I think we will have to move on.

Senator Moseley-Braun please?

Senator MOSELEY-BRAUN. Thank you, Mr. Chairman. I will try to be to the point.

I want to explore a couple of Dr. Goodman's assumptions. First, on the issue of disability in the States, and having a national versus a State-dictated definition, you said in your statement that you thought that local communities should decide on what constituted disability. And that should be predicated on the local community's decisionmaking and values.

I raise for you the question, in a situation, for example, in which an individual who had HIV was unable to get private insurance because it was considered a preexisting condition. And the State, for whatever reason—the Governor could be homophobic or whatever, or the person did not have a constituency large enough to win a referendum, or whatever the issue was—the State decided HIV is not going to be covered. HIV will not be a disability for purposes of our Medicaid program.

As a national community, we would then be unable to respond to that person's need, based on the formula that you suggested.

Dr. GOODMAN. Well, clearly we are not going to let localities make any decision they happen to want to make. The questions is, how much freedom should they have?

If Congress does not like what is happening in the local communities, if they think that a particular type of disabled person is being discriminated against, they can change the rule. But I think, for the most part, when values differ, decisions about values should be made locally, not Federally.

Senator MOSELEY-BRAUN. All right. But that is not what you said to begin with. That is why I wanted to explore the assumption. Because what you said to begin with would not suggest that kind of safety valve.

Dr. Reischauer?

Dr. REISCHAUER. You know, we have a national floor definition already included in the Supplemental Security Income law. And that is established for income support, and I see no reason at all why that floor should be different for medical support, which is for disabled individuals every bit as important as income support.

Now maybe Dr. Goodman would like to lower that definition across the nation as the floor, and that is certainly a reasonable debate. But we have it already, we are using it already, and it does not seem to make sense to change that policy and differentiate the definition for medical services from that which we already use and will continue to use in the future for income support.

Senator MOSELEY-BRAUN. Any other comments?

Mr. TALLON. I largely agree with Dr. Reischauer on that.

Senator MOSELEY-BRAUN. A second question, and again this is from Dr. Goodman's testimony. You said on page 3, "Federal, State and local governments spend about $350 billion per year on more than 300 means-tested programs aimed at assisting the poor."

And the next statement is, "And yet today's poverty rate of 15.1 percent is higher than the 14.7 percent in 1966, when the War on Poverty began."

I want to ask the question whether or not you are assuming a connection between our having means-tested programs aimed at assisting the poor and the rise in the poverty rate?

Dr. GOODMAN. Oh, I think that is right. I think that these Federal programs lowered the poverty rate through the early 1970's,

but then it turned around. And I think they induce people at the margin to decide to be poor rather than non-poor so that they can qualify for benefits. I think that definitely happens.

Senator MOSELEY-BRAUN. Well, except that we have economic numbers here from the CRS Congressional Budget Office that show very clearly that, in the absence of these programs that you have mentioned, the poverty rate would be 22.5 percent, and that there has been a reduction in the poverty rate of almost 10 percent just by virtue of the effort we have been making to rectify that.

Dr. GOODMAN. Well, I disagree with that. A couple of years ago, the Council of Economic Advisers did a projection that started way back at the end of World War II. And they asked what would happen to the poverty rate with no Great Society programs at all, just from economic growth alone. What would we predict that it would be today? It is not much different than it now is.

So I do not agree with the forecast that you mentioned. And I think that by and large, at the margin, these programs are causing the poverty rate to be higher than it otherwise would be.

Dr. REISCHAUER. Can I just add to that? What I think you have here is the comparison of a static analysis by CRS with a dynamic situation that Dr. Goodman is talking about. And to bridge the difference, I would say that I unquestionably agree with the direction of the response. The existing income maintenance system has had some incentives that have increased the size of the poverty population.

Now the question is, by how much? And I would answer that it is very tiny, and that most of the spending goes to improve the lots of people and to help their circumstances, raise them out of poverty or closer to the poverty line, at they same time that there is this very negative and pernicious impact on some small portion of the poverty population that acts to keep them in poverty or moves them from a self-sufficient situation to a dependent situation.

And, you know, that is an empirical issue which we can argue about.

Senator MOSELEY-BRAUN. Well that is why I raised the question. Because it would seem to me that, if you did nothing, no cash assistance, transfer payments or any of this, people would be worse off than they are. And that is not what we are talking about.

Dr. GOODMAN. But no one is proposing doing nothing.

The CHAIRMAN. I think the time has come that we have to go and vote.

Again, let me thank each and every one of you for being here. It has been very helpful, and we will call upon you in the future.

[Whereupon, at 12:38 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MAX BAUCUS

Thank you, Mr. Chairman. I appreciate your holding this hearing, and I thank Secretary Shalala for coming here today to testify on the Governors' proposals on Medicaid and welfare.

I commend the Governors for their efforts to work together to try and reach a consensus on the policy changes that should be made to the Medicaid and welfare programs. These debates have sometimes brought more heat than light in Congress, and the Governors should be congratulated for working together.

Before I discuss these proposals, though, I want to thank you, Secretary Shalala, for your help with Montana's Medicaid mental health waiver proposal. I appreciate your personal involvement, and I know Governor Racicot was quite pleased with the meeting he had with you. I hope you and your staff will continue to work with the Governor and the MT Department of Public Health on a plan that allow for maximum state flexibility, while ensuring access to quality mental health services for Montana's Medicaid population.

Now to the NGA proposals.

WELFARE REFORM

We need welfare reform and we should have it this year. The reason we have a welfare system is to help people in a tough spot get back on their feet and back to work. To promote the values of work, personal responsibility and self-sufficiency we all share as Americans. Our present system fails to do that, and that is a tragedy. I believe this Congress needs to make some decisions and get the job done.

The Governors have made an important contribution to the debate, and today we have an opportunity to discuss their welfare reform plan in detail. As we start, I want to raise two specific concerns.

One, the plan creates a new pool of child care money and a new contingency fund. I support those ideas. But I also think states need to bear part of the burden, and should provide some matching funds.

And two, I also have serious reservations about the provision which sets a 12-week limit on the ability of states to count job search and job readiness as a work activity. This is too prescriptive. I believe states should have the option for more flexible work requirements.

Our goal here is to get people off welfare and into the world of work. And if welfare recipients are to succeed in that world, they need skills. Many will need education and job-training support to succeed at entry-level jobs. A bill that discourages states from offering more than three months of training could ensure failure on the job and thus defeat the entire purpose of welfare reform. So this provision needs some big changes.

MEDICAID

I am committed to providing health services to poor people, seniors and people with disabilities is a hallmark of a decent society.

With all its problems, that is what Medicaid represents. We need to save money and we need to make the program more flexible. But we also need to make sure Medicaid beneficiaries have access to decent medical care. With that in mind, I want to raise four concerns about the NGA plan in its present form.

First, I support the Governors' efforts to preserve eligibility for services for some of the core population now receiving Medicaid coverage. But the plan is ambiguous at best on coverage for the disabled. That should not be put in question.

Second, I am also concerned that the NGA plan may not provide sufficient coverage for poor children aged 13 to 18. These kids are now scheduled to be phased in for mandatory Medicaid coverage, but the NGA plans leave them out. This needs to be rectified.

Third, we need more information on the plan's implications for the health needs of children. As I read the "Treatment" part of the program, states might no longer be responsible to provide for necessary health services for children, and that concerns me a great deal.

Finally, I think the plan may go too far in watering down standards for the "amount, duration, and scope" of services. These standards were created to make sure services would not be arbitrarily limited or reduced. I am very concerned that, in pursuit of the worthy goal of flexibility, the plan may lead to a lower standard of coverage for the Medicaid population.

In summary, there is a long way to go if we are to take the NGA blueprint and turn it into workable welfare and Medicaid reform legislation. However, the Governors have done the country a service by putting party interest aside and working together. I commend their work. And I hope the committee, and particularly our colleagues on both sides of the aisle, can learn from their example so we get a successful reform this year.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF ROBERT B. CARLESON

Chairman Roth, members of the Committee, thank you for the opportunity to testify today in support of the historic policy position on welfare reform of the National Governors' Association, which was adopted unanimously by them on February 6, 1996, Ronald Reagan's 85th birthday.

I have been working on the welfare issue since August 1970 when then Governor Reagan "drafted" me into welfare; first as a member of his Welfare Reform Task Force, and then as Director of the California Department of Social welfare. I was considered the chief architect and implementor of his successful welfare reforms of 1971 and 1972.

When Cap Weinberger became Secretary of Health, Education, and Welfare in the second Nixon Administration he appointed me U.S. Commissioner of Welfare with instructions to carry Reagan style welfare reform to other States. As a result, the nation's welfare rolls dropped in 1974 for the first time since World War II; as they had done with our earlier reforms in California.

I wrote AFDC block grant bills for the House and Senate in 1978 as alternatives to President Carter's welfare expansion proposal. These bills, respectively, won the unanimous support of House Republicans, many House Democrats and the bipartisan leadership of your Committee. As a result the Carter reform died in this Committee.

As Special Assistant to the President for Policy Development in the Reagan White House, I wrote the successful 1981 welfare reforms which were part of the Gramm-Latta Budget Reconciliation Act. I left the White House in 1984 and was not a party to the 1988 welfare reforms which were inspired by Senator Moynihan.

Since 1971 , Ronald Reagan and I have had several lengthy discussions about welfare reform. It has been his most fond dream that the AFDC be replaced with finite block grants to the States with no federal strings attached. I have been working to this end for most of the last 25 years. We are now close to achieving 90% or more of his goal. We may never have this opportunity again. It is a near miracle that the National Governors' Association adopted unanimously a welfare reform plan which virtually would enact Ronald Reagan's dream. Predictably, it is being aggressively opposed by the same welfare industry which has so long fought Ronald Reagan every step of the way.

We should not quibble about truly insignificant details and let this opportunity slip away, maybe forever. Those who worry about the budget should observe that the repeal of this historically "uncontrollable" open-ended program and its replacement with finite appropriations will for the first time make it eminently controllable. Without this change any budget numbers, however they may appear to be cut or reduced, will be based on ephemeral policy changes which will be meaningless and which have historically resulted in increased expenditures. (see the 1988 welfare reform) The additional spending called for in the Governors' plan would be fi-

nite appropriations and thus controllable—well worth it from a budget point alone because of the repeal of the open-ended uncontrollable current system.

For those who worry about illegitimacy and the family cap, don't let the perfect defeat the good. Contrary to articles written by Robert Rector of the Heritage Foundation the Governors' plan does support marriage and condemns illegitimacy by supporting the findings and purposes sections of H.R. 1 unchanged. These finding and purposes are the most detailed and complete statements ever made by the Congress in support of marriage and in opposition to illegitimacy: Current law permits no family cap, unless a federal waiver is given. Although 20 States have be.en given these waivers they have been slow to be granted and are burdened with conditions and definitions which make them expensive and often self defeating. The Governors' plan gives the States complete control without the possibility of interference from the federal government. With no reform, in my opinion, State waivers will end as soon as it is politically expedient. Holding out for a mandatory State opt-out provision is a distinction without a difference and would kill welfare reform—thus retaining the current prohibition of a family cap.

In this year of Ronald Reagan's 85th birthday the Governors' welfare reform plan should be passed quickly, without change, and laid on the President's desk. No changes should be made to ensure that no excuse can be given for any Governors who may be pressured by the welfare industry to back off their commitments to do so, or for the President to use his veto.

In summary, the Governors' welfare reform plan is not a compromise with Ronald Reagan's dream of true welfare reform. It achieves as least 90% of his dream. We must not let this historic opportunity slip away. Any statements to the contrary come from people who do not know Ronald Reagan's long-held views on true welfare reform. I do.

PREPARED STATEMENT OF HON. JOHN H. CHAFEE

I would like to take this opportunity to commend the National Governors' Association, and especially those Governors who worked so hard to reach these agreements on Medicaid and Welfare Reform. I certainly understand how difficult it was for you to reach a consensus on these controversial issues. I am hopeful that your input will move us further along in this process.

As a former Governor, I appreciate the challenges and frustrations you face as these programs consume an increasing percentage of your state budgets. At the same time, I hope you understand the challenges and frustrations that we face here in Congress in trying to strike a balance among: (1) controlling federal expenditures; (2) asking the states to be accountable for the federal contribution; and (3) the need to preserve an adequate safety-net for our most vulnerable populations.

While I am impressed that you were able unanimously to approve your proposal to reform the Medicaid program, I must say that I am concerned about several aspects of the agreement. First, I am concerned about the possibility that many individuals with developmental disabilities may face losing their sole source of health care coverage. As we move forward in this process, we must realize that, for most of these individuals, Medicaid is the only option. Even if they could afford private insurance coverage, in most cases, insurers would not sell them a policy because of pre-existing conditions.

Second, I am concerned about the possibility, that under your approach, states would be able significantly to reduce spending on health care services for low-income populations. Not only is the state minimum matching requirement reduced from 50% to 40%, but the repeal of provider tax and donations restrictions, could put states in the position of drawing down federal matching dollars for funds that are never spent on Medicaid services. This was a scandal which we put limits on in 1991 with the help of the Governors.

On the subject of welfare, the Senate passed a good welfare bill, with broad bipartisan support—87 to 12. We all, Republicans and Democrats alike, worked hard to strike a compromise and the wide support for that bill speaks to our ability to come together. The conference agreement on welfare reform, which has already been vetoed by the President, fell short in several key areas—foster care and children's SSI, to name two. We should consider, I believe, using the Senate bill as a starting point.

Some of the provisions in the NGA welfare proposal follow the Senate bill, such as children's SSI, food stamps and the so-called "family cap." But in other key areas, the NGA proposal strays from the Senate bill. The state maintenance of effort requirement is weakened for the overall block grant and for specific areas such as child care and the contingency fund. Under this proposal, states would have no financial incentive to provide more than 75 percent of their current expenditures for

welfare programs because there no longer is an additional federal contribution. This could potentially draw significant sums of money away from programs which are critical to the success of welfare reform, such as child care and job training.

Another area of particular interest to me is the foster care program. The NGA proposes a child protection block grant of all child welfare programs other than foster care and adoption assistance. Additionally, states could choose, every year, whether to take a block grant comprised of their foster care and adoption assistance money. This proposal troubles me. While I am optimistic about the outcome of this welfare reform program and the states' ability to reduce caseloads, the jury is still out. Until we know for certain that it will not result in more children in the foster care system, it seems to me we need to keep that program intact as the last safety net for children who may be unable to remain in their homes. The Senate bill did this.

Having raised these concerns, I look forward to hearing from the Governors today. I am hopeful that we will be able to follow your example and reach a bipartisan agreement in Congress to reform these critical safety-net programs. Thank you Mr. Chairman.

PREPARED STATEMENT OF HON. LAWTON CHILES

It has been almost a year since I last appeared before this Committee on the subject of Medicaid reform. Last year when I testified, I focused on what I felt were the obvious inequities of the block grant approach for high-growth states like Florida. I was concerned that the part of the program that I couldn't control was going to have a hard cap. That is, the people who move to my state, age in my state and need more and more services in my state, would not have been counted.

The federal government was going to give me some money on a stump, hope it was going to be enough and send me on my way. If they estimated my growth needs incorrectly that was my state's problem. If they overestimated another state's growth needs, that was their windfall.

Ironically, two of the Governors here today also appeared before this Committee on that day. But we were on opposite sides of the issue. We come here today with our best attempt at resolving our differences.

Our structure is not perfect. It certainly cannot replace the 30 years of hard work which this Committee has put into the Medicaid program. It is not based on any proposal in the Congress. It doesn't assume MediGrant I or MediGrant II or any of the Per Capita Cap bills as its foundation. It does not repeal Title 19 or incorporate the legislative language of other proposals. It stands on its own; as an outline of what Governors think the future of the Medicaid program should look like. It is at best an outline—but we think, it is nonetheless important. We know this outline can be improved—and, we hope to work with you in a bipartisan way to do just that.

Medicaid is much more than just an ideological concept for Governors. This program monopolizes our attention, our planning, our rendering of services—and, most importantly our state budgets. We all want to reform this program. We hope we have provided you with a blueprint to do the job right.

I'd like to focus today on the critical guarantees this proposal provides. First, it provides a guarantee of eligibility *to the individual.* In earlier proposals, *set-asides to groups* were used to try to ensure that individuals received coverage. The Governors' proposal changes that. We maintain the strength of the current law for eligibility. If you are eligible for Medicaid today, with few exceptions, you will be eligible under this new program.

States will be required to serve:

All Pregnant Women below 133% of poverty;
All Children up to Age 6 under 133% of poverty;
All Children 6-12 under 100% of poverty;
All AFDC recipients (through current AFDC or a new cash assistance program);
All People with Disabilities as defined by the state and approved by the Secretary of HHS;
All Elderly SSI recipients; and
All Poor Elderly Recipients on Medicare for the cost of their premiums, co-pays and deductibles.

In addition, the eligibility categories that are optional today would remain optional. But the fundamental principle that our most vulnerable populations should be *individually guaranteed* entry into the program is what helped bring our group together. It is this structure that is critical to any reformed Medicaid program. In

the Governors proposal, individuals are guaranteed coverage if they are in these federally defined classes—as they are today under current law.

Today, when a pregnant woman at 125% of poverty walks into a Medicaid office she is guaranteed entry into the program. Earlier proposals would have had her eligibility left up to the state. Under the earlier proposals, if the state had spent enough on that class of people it had no obligation to serve her as an individual. The Governors' proposal rejects that approach. That pregnant woman, indeed any pregnant woman under 133% of poverty, is automatically eligible for Medicaid.

Some of my colleagues will discuss the flexibility we are seeking to tailor our benefits package to specific populations. We think it is important to maintain a meaningful safety net on benefits. For all guaranteed groups under our proposal—the current mandatory benefits package, with few exceptions, would continue to be mandatory. States would have some discretion beyond that mandatory package to tailor specific benefits to populations in need. We hope that will enable us to expand the safety net to the working poor who by and large today have no health coverage.

This flexibility we're asking for is nothing new to many members on this Committee. It is what drove many of you and some of my Republican colleagues at this table to support a block grant for Medicaid. But in our agreement, the Governors wanted to make sure, that the flexibility they got was real.

None of us want the flexibility to slash the program. But under some of the earlier proposals that's what flexibility would have meant. Because of the magnitude of the cut, we would have been forced to use our flexibility to reduce our rolls. And because the federal government's participation was absolutely limited through an *aggregate cap* on federal spending, states would have been left with no federal partner.

This is where as Governors we have taken a strong bipartisan stand—*our proposal does not have an aggregate cap.* Our entire compromise is constructed around two fundamental principles—flexibility to the states and a true federal/state partnership for financing.

These two principles must be linked. You cannot have true flexibility with a federal partner that can bail-out in the tough times. And, you can't achieve the savings you need without allowing states the flexibility to run this program more efficiently.

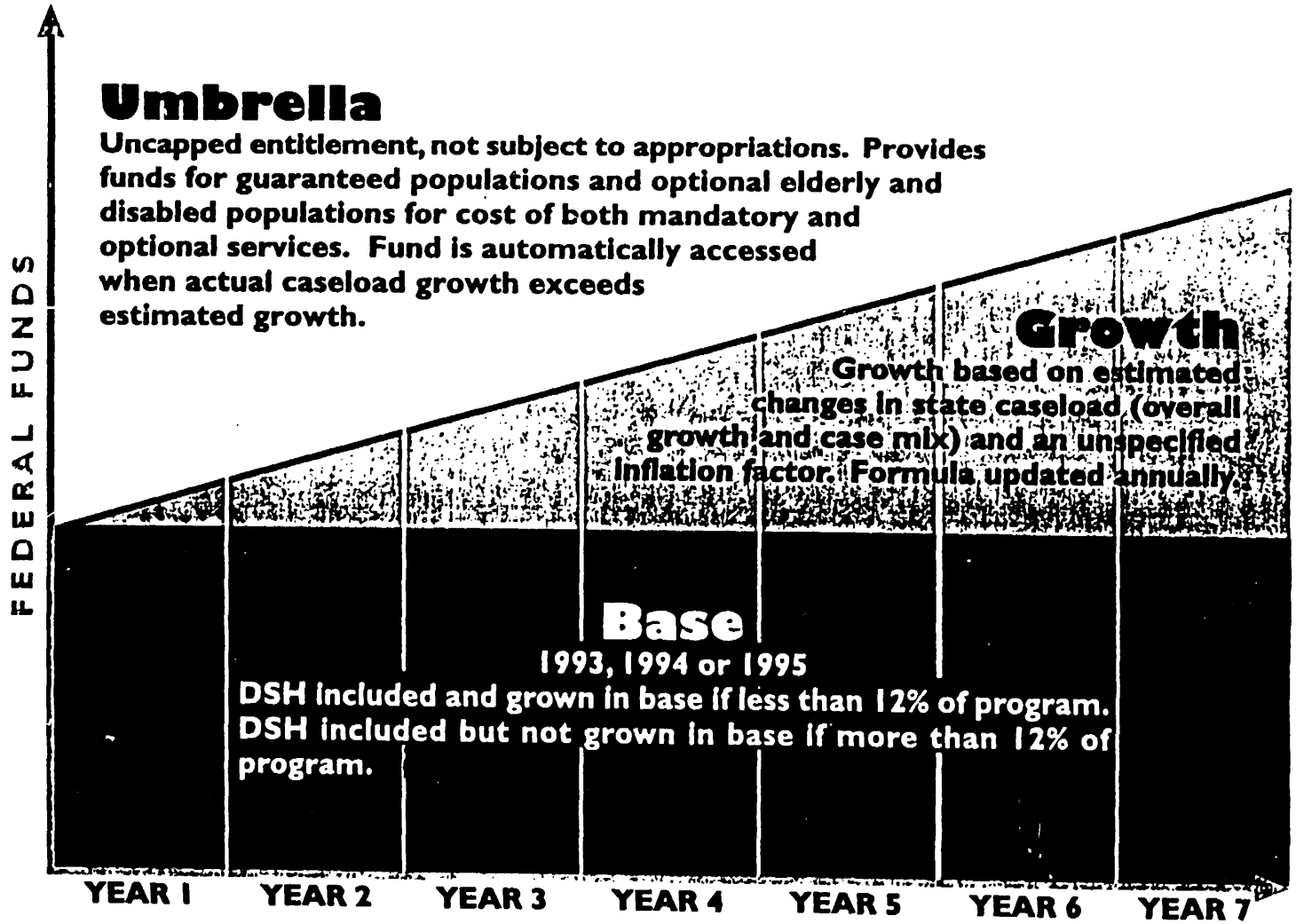
My colleagues will talk about our plan for financing this program. I want to emphasize this point on which we all agree. The umbrella fund in our proposal is uncapped; it is not subject to appropriation; it is an entitlement. When more people become eligible for the program than expected the umbrella responds *automatically,* helping to provide critical health services to the individual.

If we experience a recession in Florida and suddenly have an increase in the number of poor children eligible for Medicaid the federal partner will be there, automatically, sharing the burden with the state. If there is a natural disaster, the federal partner will be there, automatically. My state was devastated by Hurricane Andrew in 1992. Overnight we had an extra 12,000 people eligible for Medicaid in Dade County. Without a strong federal partner during those difficult times, we would have been on our own. Those families that needed care would have been in serious trouble.

Many see this as a protection for state budgets. I see it as protection for the individuals in this program. That structure cannot be changed. It is the core of our agreement. It is why this group is before you today. It is a true compromise.

Giving a state flexibility without adequate resources to cover the needy would force states to cut their rolls, slash services and undermine the overall health of their population. I know we all share a commitment to maintain this critical safety net. And as Governors, we are ready to begin work on a true bipartisan approach to reform the Medicaid program.

I know we all look forward to getting this job done right.


FEDERAL FUNDS
Umbrella
Uncapped entitlement, not subject to appropriations. Provides funds for guaranteed populations and optional elderly and disabled populations for cost of both mandatory and optional services. Fund is automatically accessed when actual caseload growth exceeds estimated growth.
Growth
Growth based on estimated changes in state caseload (overall growth and case mix) and an unspecified inflation factor. Formula updated annually.
Base
1993, 1994 or 1995
DSH included and grown in base if less than 12% of program.
DSH included but not grown in base if more than 12% of program.
YEAR 1
YEAR 2
YEAR 3
YEAR 4
YEAR 5
YEAR 6
YEAR 7

PREPARED STATEMENT OF SHELDON DANZIGER [1]

I appreciate the opportunity to testify this morning.

Welfare is a controversial subject, too often discussed out of context. The welfare problem is best understood in the context of the economic changes that have affected our economy for the past two decades, during Republican and Democratic Administrations alike. During this period, powerful changes in the economy have diminished the economic prospects of millions of Americans, have caused rising economic insecurity, and have kept the poverty rate and the need for government assistance at a high level. As a result, economic and social policies should not be approached as if they represented independent realms. The struggles of middle-class families to meet mortgage payments and college expenses, the falling real wages of less-educated workers, and the labor market difficulties of the working poor and welfare recipients are interconnected.

This economic context makes it difficult for us to transform welfare from a safety net that provides cash assistance to one that provides employment assistance. Nonetheless, we should transform the entitlement to a welfare check into an entitlement to the opportunity to work. Welfare recipients should be expected to look for work, but if they diligently search for work without finding a job, they should, at a minimum, be offered an opportunity to perform community service in return for continued welfare assistance. Such a transformation to a work-oriented welfare system is consistent with the principles of The Family Support Act. It is also consistent with the welfare reforms that have been proposed in several states.

The proposal put forward by the National Governors' Association, however, eliminates any assurance that families in need receive assistance and imposes time-limits on welfare benefits for those families states choose to serve. This would terminate the entitlement to welfare without guaranteeing a work-for-assistance alternative for recipients who are willing to work. This would eliminate the cash safety net for those who reach a state's time limit, and would at state option, allow the elimination of the food stamp entitlement.

States could eliminate benefits for two-parent families, sharply reduce benefits or turn away some of those who are eligible in response to a recession or any budget crisis. Under current law, a family with no current income and low assets is eligible for cash assistance and food stamps in every state. This is the very definition of a safety net. If the Governors' plan were to become law, given the nature of today's labor market, many recipients who were willing to take responsibility for their families would almost certainly find themselves without any cash income or food assistance.

Everyone would agree that our current safety net programs can be improved. They do, however, alleviate some of the negative effects of poverty on children and remove from poverty about 8 million children who would be poor if they had to rely only on their parents' market incomes. I am greatly concerned that the program changes included in the Governors' proposals do not do enough to raise the employment prospects of welfare recipients, allow the states to significantly reduce their own spending, and thus, will lead to a large increase in our already high child poverty rate. [2]

Most of my testimony focuses on the employment prospects of welfare recipients. Before I turn to that, I will briefly elaborate on these latter two issues. The Governors' proposal is likely to reduce total state spending on programs for the needy. A recent review of the economics literature concludes that there will be a twenty percent decline in the basic cash grant in the first few years following passage of a block grant proposal. [3] In expectation of a block grant funding mechanism, several states have announced their intention to cut AFDC benefits significantly and there is no evidence that the reduced spending on cash assistance would be used to increase spending on welfare-to-work programs.

The Office of Management and Budget has shown that the conference version of welfare reform would have added an additional 1.5 million children to the poverty roles. It is possible that under the Governors' proposal, states would withdraw even greater amounts of funds, causing this number to increase.

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[1] This testimony is based in part on Sheldon Danziger and Peter Gottschalk, *America Unequal* (Harvard University Press/Russell Sage Foundation, 1995)

[2] Using comparable data from a number of countries, the Luxembourg Income Study reports that child poverty in the U.S. is much higher than in other advanced economies. In the early 1990s, the child poverty rate in the U.S. was more than 20 percent; it was about 14 percent in Canada and Australia and less than 5 percent in Scandinavia and Northern Europe.

[3] Howard Chernick, "Fiscal Effects of Block Grants for the Needy: A Review of the Evidence." Hunter College: Department of Economics, October 1995.

THE ECONOMIC CONTEXT OF WELFARE REFORM

The past two decades have been characterized by economic distress for the middle class, the working poor, and the unemployed, as well as for welfare recipients. There has been relatively little economic growth over the past generation, and the gains from growth have been very uneven. In the two decades following World War II, "a rising tide lifted all boats." During economic recoveries all families gained—the poor as well as the rich, the less-skilled as well as the most-skilled. During the 1980s recovery, however, a rising tide became an "uneven tide," as the gaps widened between the rich and the poor and between the most-skilled workers and the least-skilled workers.

Economic hardship is remarkably widespread, even among young workers with high school and college degrees. In 1991, among 25-to-34 year old college graduates (without post-college degrees) 16 percent of men and 26 percent of women worked at some time during the year but earned less than the poverty line for a family of four persons (about $14,000 in that year). About one-third of all male high school graduates and more than half of all female graduates in this age cohort earned less than this poverty line.

The primary source of this economic hardship has been a set of structural changes in the labor market. Many workers, especially those with less education and less experience find it harder to secure employment, and those who are hired tend to receive low wages. The continuing decline in employer demand for less-skilled workers will not be reversed by welfare reform.

Welfare reform affects the supply side of the labor market by increasing the incentive of welfare mothers to search for work. Employers, however, control the demand side of the market and they require diplomas, experience, and references. About 50 to 65 percent of all newly-available jobs where employers do not require a college degree require each of the following on a daily basis: reading of paragraphs, performance of basic arithmetic calculations, dealing with customers and use of computers. Only about 5 to 10 percent of new non-college jobs require none of these tasks on a daily basis. [4]

In contrast, most welfare recipients, especially long-term recipients who would be subject to time limits, have limited education and labor market experience, score poorly on tests of basic skills, and are disproportionately located in low-income inner-city neighborhoods, where there are few job opportunities, and from which they have difficulty commuting. Lack of information about suburban job vacancies and racial discrimination also diminish their prospects.

Many will have difficulty obtaining any job offer, even if they search extensively. Others will obtain work, but frequently lose jobs due to poor work preparation or performance, absenteeism caused by child care or transportation problems, or the sporadic nature of many low-wage jobs. Because of these labor market problems, even the most successful welfare-to-work programs (e.g. Riverside, California's GAIN program) have rarely obtained long-term employment rates of 50 percent.

It is simply not the case that most of today's welfare recipients could obtain stable employment that would lift them and their children out of poverty, if only they would try harder. Fear of destitution is a powerful incentive to survive. It does not, however, guarantee that an unskilled worker who actively seeks work will find a job. Even if she does, it does not guarantee that she will earn enough to keep her children out of poverty.

The harsh realities of today's labor market mean that changes in welfare mothers' economic incentives—such as those embodied in time-limited welfare reforms—are unlikely to make much of a difference unless they are accompanied by changes in their employment opportunities.

WHAT CAN POOR PARENTS DENIED ASSISTANCE EXPECT TO EARN?

Poverty rates are high, and earnings tend to be low even for working single mothers who do not now receive any cash welfare. Compared to these mothers, welfare recipients have less education, are younger, have more children and are more likely to be never married. For example, about one-quarter of nonrecipients, but half of recipients are never-married; about one-fifth of recipients, but two-fifths of nonrecipients lack a high school degree; about one-sixth of nonrecipients, but one-quarter of recipients are below 25 years of age; about one-sixth of all nonrecipients, but one-third of recipients have three or more children.

All of these observed characteristics suggest that welfare recipients are likely to earn less than nonrecipients. I have used detailed Census Bureau data on employ-

[4] Harry J. Holzer, *What Employers Want: Job Prospects for Less-Educated Workers,* (Russell Sage Foundation, 1996).

ment and earnings to estimate the extent to which a welfare mother can expect to earn more than the poverty line for a family of three persons (about $12,000 in 1994).[5] Whereas 64.3 percent of nonrecipient single mothers earned more than this amount, only 41.5 percent of welfare mothers are predicted to earn that much.[6] (Those parents able to earn this much are more likely to stay on welfare for short periods of time.) In addition, while these estimates control for years of schooling, they do not control for labor force experience or skill level. Thus these estimates overstate the potential earnings of welfare recipients.

The attached figure presents the results for a single mother of two children living in the city of Detroit. The labor market prospects of a welfare mother vary widely, depending on her race, education, age, and marital status. Most white and black women between the ages of 36 and 45 with high school degrees can earn enough to escape poverty. However, only 8 percent of black, never-married mothers who are between the ages of 18 and 25, lack a high school diploma and have young children can earn that much.

The 1991 termination of the General Assistance (GA) program in Michigan also demonstrates the labor market difficulties of less-skilled individuals.[7] Among former GA recipients who were under the age of 40 and who had not qualified for disability benefits two years later when they were interviewed, about two-thirds had worked at some time in the two years following their termination. But two years after benefits had ended, only one-half of those with a high school degree or a GED were working. They earned, on average, $596 per month. The situation for those who lacked a degree was even worse. Only about one-quarter of these former recipients were working, for wages averaging $377 per month. This suggests that welfare recipients who reach the time limit, but are not offered work opportunities, will have difficulty obtaining and holding onto jobs.

Another recent study documents the inhospitable nature of the inner-city labor market.[8] All job openings at four fast-food franchises in Harlem were surveyed and the work histories of successful and unsuccessful job applicants were compared. For each job filled, there were 14 applicants. Job holders were better educated and had better job contacts than the unsuccessful applicants, but the unsuccessful applicants were on average better educated and had more job experience than the typical welfare mother who would face time limits. Three quarters of the rejected applicants continued to search for work but were unemployed when interviewed a year later.

These empirical findings suggest that as long as America remains committed to the view that a child should not have to suffer the consequences of poverty merely because his parent can not find work, debates about welfare reform should continue to be primarily debates about what kind of government intervention we should provide.

A WORK-ORIENTED SAFETY NET

Given the state of the labor market and the characteristics of welfare recipients, it will not be easy or inexpensive to transform welfare to a work-oriented safety net. Poverty and welfare recipiency remain high because of a failure of the economy to raise the living standards of average workers and the failure of government to adapts its policies to deal with this changing economic environment.

More attention must be given to the demand side of the labor market. Low-wage public service jobs of last resort for the poor would be the best way to transform our safety net. Given the current budgetary context, however, an alternative is to provide the kind of work-based safety net that Governor John Engler has proposed for Michigan (for a pilot project in a number of counties). His proposal allows recipients who cannot find employment to perform community service in return for continued cash assistance, regardless of the length of time they have been on welfare. This provision is important in its own right in an economy in which the trend toward downsizing shows no sign of slowing. It will be critical during any future recession, when employer demand for low-skilled workers will be even lower than it

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[5] See Sheldon Danziger and Jeffrey Lehman, "How Will Welfare Recipients Fare in the Labor Market?" *Challenge Magazine*, March/April 1996.

[6] This estimate assumes that the child care needs of welfare recipients could be met just as they are now met by working single mothers. These estimates are based on annual earnings only and do not reflect receipt of food stamps or the earned income tax credit and they do not subtract child care or medical care expenses.

[7] See Sandra K. Danziger and Sherrie A. Kossoudji, *When Welfare Ends: Subsistence Strategies of Former GA Recipients*. University of Michigan School of Social Work, February 1995 and Sandra K. Danziger and Sheldon Danziger, "Will Welfare Recipients Find Work When Welfare Ends?" Urban Institute, Welfare Reform Brief, No. 12, June 1995.

[8] Katherine Newman and Chauncey Lennon, "Finding Work in the Inner City," Columbia University, Department of Anthropology, February 1995.

is today. I would urge the committee to include such a "work-for-your welfare" community service mandate in its welfare reform legislation.

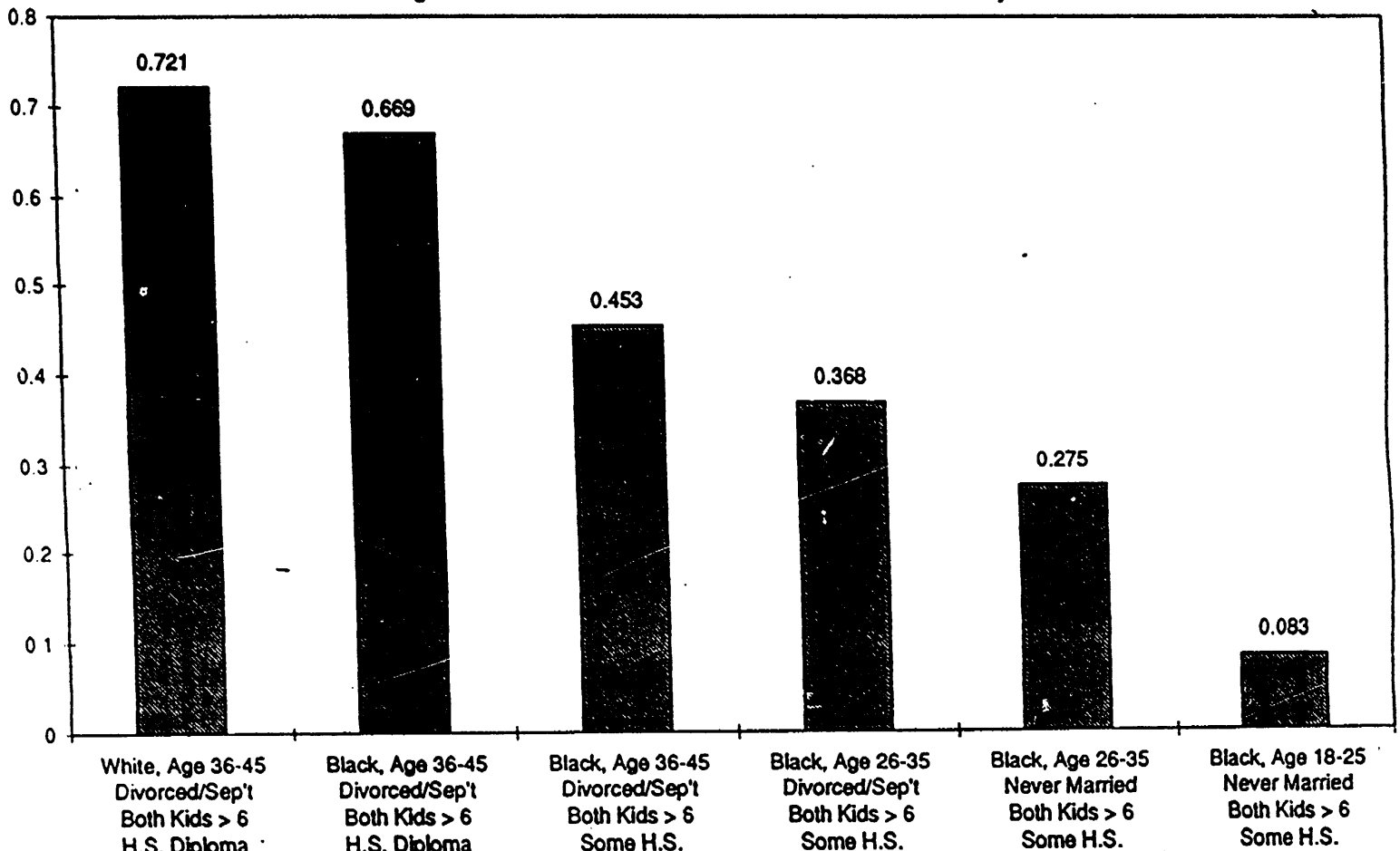
To make it possible for mothers to work, child care assistance and Medicaid protection are also essential. Funds for job counseling, training, and transportation would address the reality that many mothers, even with the best intentions, will not be hired in the current labor market. Most important, however, is the maintenance of the Earned Income Tax Credit so that working poor families can better feed, clothe and shelter their children.

The Great Depression taught Americans that individuals can be unemployed and/or poor through no fault of their own. Because we have experienced two decades of slow economic growth and rising inequalities the same is true today. We should not allow our overall affluence to block out the less-visible, quiet depression that has affected our most disadvantaged citizens.

Thank you again for the opportunity to testify.

FIGURE

Probability of Earning More Than the Poverty Line for a Family of 3
Selected Single Mother Families with Two Children in Central City Detroit



PREPARED STATEMENT OF JOHN C. GOODMAN

Thank you Mr. Chairman. It is now universally acknowledged—by Democrats, as well as Republicans; by liberals, as well as conservatives—that we cannot get the federal government's fiscal house in order unless we have radical reform of the nation's entitlement programs. With respect to reform of Medicaid, I would like to make six points:

1. Medicaid spending has been growing at an unsustainable rate, and (along with Medicare) is the chief cause of the rampant health care inflation we have experienced over the past 30 years.
2. There are three reasons for escalating Medicaid costs: (a) patients and providers face perverse incentives that encourage waste fraud and abuse; (b) federal rules and regulations have inhibited the adoption of cost control techniques commonly employed by the private sector; and (c) the Medicaid population is growing because Medicaid, along with other federal welfare programs, is inducing more and more people to be poor, rather than nonpoor, and qualify for benefits.
3. The problem is made worse by the fact that states themselves have weak incentives to control waste—they get to keep only about 50 cents of every $1 of waste they eliminate.
4. The ideal solution is to block grant Medicaid, along with all other federal means-tested poverty programs, to the states with few, if any, strings attached.
5. Although the solution proposed by the nation's governors stops short of the ideal, it is a step in the right direction.
6. In implementing the governor's solution, Congress should be careful not to restrict highly successful welfare reforms currently underway; Congress should also consider a state option for taxpayer choice—allowing taxpayers to allocate their own share of welfare tax dollars to any qualified private charity. Let me briefly expand on each of these points.

EXPLODING MEDICAID COSTS

Medicaid provides health insurance and nursing home services for about 36 million Americans, at an expected cost to the federal and state governments of about $157 billion in 1995. Of the 36 million Americans currently enrolled in Medicaid, 27 percent are blind, disabled or poor elderly adults. Another 50 percent are infants and children, most of whom receive Aid to Families with Dependent Children (AFDC). Medicaid also pays for one-third of all U.S. births.

Medicaid spending has been exploding—growing from $51.3 billion in 1988 to an estimated $157 billion in 1995—tripling in just eight years. In addition to the direct burden this program creates for taxpayers, it creates an indirect burden by contributing to general health care inflation.

The NCPA/Fiscal Associates Health Care Model shows Medicare and Medicaid are the primary reason why health care spending in the United States ballooned:

- Over the past three decades, the share of private health care spending in total U.S. consumption grew at an annual rate of 1.3 percent.
- The share of government health care spending in total U.S. consumption grew at three times that rate. Moreover, both NCPA and Department of Health and Human Services studies show that each new dollar spent on health care buys about 57 cents in higher prices and only 43 cents in real services.

WASTEFUL SPENDING

One reason for the spending explosion is that Medicaid recipients bear virtually none of the cost of their health care and thus have no incentive to be prudent consumers. Another reason is that doctors and hospitals have weak incentives to deliver care efficiently.

As a result of these and other perverse incentives, fraud and abuse run rampant. Take the case of Walter Wilbon, who the Chicago Tribune says is a "Medicaid con man." The Illinois Medicaid records show that in just one year Wilbon made 426 visits to 111 different doctors. He underwent 559 blood and urine tests and visited 115 different pharmacies.

So what illnesses does Wilbon have that prompt so many contacts with the medical community? Actually, that's not clear. Although he racked up a total of $101,442.62 in Medicaid bills in 1991, he was never hospitalized. And although he convinced doctors to diagnose him with 28 different illnesses—ranging from diabetes to asthma—there's no hard evidence that he has any of these afflictions.

Despite that fact, in a 12-month period Wilbon managed to get Medicaid to pay for 65,505 pills, 20,400 syringes and 343 bronchial inhalers. These items, in turn,

can be sold on the street. For example, drug addicts will pay as much as $1 apiece for a syringe; alcoholics will pay 37 cents apiece for the anti-ulcer pill Zantac; and people who smoke cocaine will pay $2 to $3 for a bronchial inhaler.

Unfortunately, Walter Wilbon is not alone. An extensive 1993 investigative report of the Illinois Medicaid system by the Chicago Tribune found that:

- Four Medicaid patients made more than 300 separate doctors' office visits over a 12-month period—an average of more than five visits per week.
- One patient—who made 243 doctor visits a year—saw five doctors on the same day on seven different occasions, and twice saw six doctors on the same day.
- Another patient collected 3,540 condoms, 234 asthma inhalers and enough pills to swallow at a rate of 46 per day.

There is no reason to believe that Chicago is unique. Throughout the country, "Medicaid mills" freely prescribe drugs, syringes and other medical products—paid for with American tax dollars and sold on the street by those intent on abusing the Medicaid system.

In addition to waste caused by fraud and abuse, waste is also caused by federal rules and regulations that have limited the ability of Medicaid to adopt cost control techniques that are common in the private sector. Most employers have moved from traditional fee-for-service health insurance to some form of managed care, which relies on provider incentives to control costs. Other employers have switched to high-deductible insurance and used the premium savings to provide their employees with a Medical Savings Account (MSA), which can be used to pay for small and routine health care expenditures. Medical Savings Accounts give employees a financial incentive to manage their own health care dollars. Overall, employers' health care costs declined in 1994 by 1.1 percent and rose in 1995 by only 2.1 percent.

The NCPA estimates that through Medical Savings Accounts, managed care and other program changes Medicaid reform could achieve savings of $185.4 billion over seven years without any reduction in benefits for needy people

A third reason why Medicaid costs are soaring is that the welfare state as a whole is attracting more and more people and encouraging them to qualify for benefits.

- Federal, state and local governments spend about $350 billion per year on more than 300 means-tested programs aimed at assisting the poor.
- Yet today's poverty rate of 15.1 percent is higher than the 14.7 percent rate in 1966 when the War on Poverty began.

Even worse, the welfare system has caused the work ethic of the lowest-income groups to collapse and family breakup and illegitimacy to soar.

In 1960, nearly two-thirds of households in the lowest one-fifth of the income distribution were headed by persons who worked.

- By 1991, this had declined to around one-third, with only 11 percent of the heads of households working full-time, year round.
- The out-of-wedlock birth rate of blacks has risen from 28 percent in 1965 to 68 percent in 1991.
- The rate of whites was 4 percent in 1965, and among white high school dropouts is now 48 percent.
- In 10 major U.S. cities in 1991, more than half of all births were to single women.

The collapse of work and family has bred urban decay, crime, drug addiction and numerous other social afflictions. This social tragedy is the direct result of our current welfare system. The system rewards illegitimacy and family breakup by paying women generous rewards for having children while they are single and penalizes marriage by taking away the benefits from women who marry working men. Furthermore, it rewards people for not working by giving them numerous benefits and penalizes those who return to work by taking away their benefits.

Depending on the precise combination of earnings, taxes and benefits, a welfare mother can easily face marginal tax rates of more than 100 percent. That is, she loses more than a dollar in taxes and benefits for each additional dollar she earns. Obviously, this is a severe disincentive to go to work and get off welfare.

WEAK INCENTIVES TO REDUCE WASTE

Under entitlement programs with shared federal-state financing, the federal government's share averages about 55 percent. Under Medicaid, the federal government pays about 57 percent. State governments pay the remainder with matching funds. This structure punishes the states that reduce poverty and reward those that fail. Assuming a 50-50 match, a state gets to keep only 50 cents out of a dollar of waste it curtails. Conversely, if a state generates a dollar of waste, it pays only 50 cents.

IDEAL REFORM

Reform of the Medicaid system should be based on three key components. First, Medicaid and all major federal welfare programs should be abolished and the money currently spent on these programs should be given to the states in the form of block grants. Second, states should be given the maximum freedom to create the types of health care and welfare programs they believe would work best for their citizens. Third, taxpayers should be allowed to shift welfare funding from state programs to private charities.

Block Grants. Federal funding for Medicaid and all other means-tested federal welfare programs should be sent to the states with only one proviso: that the funds be used to help the poor. Each state would then be able to use the funds, along with current state Medicaid and welfare funds, to design its own programs. These grants would replace AFDC, food stamps and public housing, among other entitlement programs.

The block grant to each state should be a fixed sum—independent of how much money the state adds to it. Current programs rely on matching grant formulas that provide more federal funds the more the state spends. As noted above, this feature encourages wasteful spending.

No Strings Attached. The block grant would free each state to experiment with entirely new approaches to welfare. States might offer work instead of welfare. They might grant funds to well-run private charities. They might come up with entirely new approaches that no one has thought of yet.

The federal government should not impede innovation and experimentation at the state level. Clearly, the federal government does not know what the right approach to welfare is, and the right approach may vary from state to state. Moreover, any attempt to impose federal restrictions on the design of state welfare programs will tend to give Washington-based interest groups greater opportunity to influence policy and short-circuit fundamental reforms. With open experimentation, by contrast, some states will be able to discover what works best and others can follow suit. Medicaid funds could be segregated in a separate block grant with the requirement that they be spent on health care for the poor. However, this requirement would be unwise. Some in Congress favor block grants in principle but would restrict them to certain categories. For example, Senator Nancy Kassebaum once proposed a federal takeover of Medicaid in return for block granting all other entitlement programs back to the states.

These proposals are misguided for two reasons. First, welfare-poverty programs do not fit into neat compartments such as food, housing, health, etc. Some of the most serious health problems of the poor are related to lifestyle—eating habits, living quarters, etc. For example, failure to get medical care, smoking and drinking during pregnancy contribute to the high rate of infant mortality and low weight of babies born to low-income women. And although there is no evidence that children from low-income families are hungry, improper diet—especially eating too few fruits and vegetables—probably contributes to higher rates of cancer and heart disease among the poor.

The key to changing behavior in ways that improve health is to package all forms of relief in ways that takes account of interrelationships among food, housing, health care and management of a family budget. Second, failure to block-grant all means-tested programs would create perverse incentives for the states. A state that had the opportunity to manage its own AFDC dollars but not its food stamps would have an incentive to skimp on AFDC benefits (which would fall fully within the state's own budget) and make up the deficit by expanding food stamp benefits (about half of which would be paid for by the federal government).

Some have already accused Michigan of engaging in this type of substitution. Governor John Engler has a national reputation as a proponent of welfare reform and has abolished welfare for able-bodied, single males. But he advocates expanding the caseload of Supplemental Security Income (SSI). The difference is that SSI is paid for with federal funds.

Taxpayer Choice. Taxpayers should be allowed a dollar-for-dollar tax credit for contributions to private charities. To the extent that a state's taxpayers utilized such credits, the state's welfare block grants would be reduced by an equal amount. Thus the revenue loss from the tax credit would be offset completely by reduced federal welfare grants to the states, leaving no net effect on the federal deficit. The maximum amount a taxpayer could donate under this program is a percent of their personal income tax payments, equal to that states block grant divided by that state's total federal personal income taxes. For the nation as a whole, this would be about 40 percent.

Block grants plus Taxpayer's Choice would give taxpayers the ultimate control over welfare. If a state misspent its block grant funds, its taxpayers could shift the funds to private alternatives that work better. Market competition between the state programs and private charities would give state welfare bureaucracies a real incentive to perform well in reducing poverty.

A mountain of evidence and experience indicates that private charities are far more effective than public welfare bureaucracies. Instead of encouraging counterproductive behavior, the best private charities use their aid to encourage self-improvements, self-sufficiency and ultimate independence. The assistance of private charities may be contingent on ending drug use and alcoholism, completing necessary education, taking available work, avoiding out-of-wedlock births, maintaining families and other positive behaviors. Private charities are also much better at getting aid promptly to those who need it most and at getting the most benefit out of every dollar.

With the tax credit, private organizations would be able to compete on a level playing field for welfare tax dollars. To the extent they convinced the taxpayers that they were doing a better job than state bureaucracies, private charities, rather than government, would be permitted to manage America's war on poverty.

THE GOVERNORS' PROPOSALS FOR MEDICAID REFORM

The states have been looking for new and innovative ways to reduce Medicaid costs. Nearly all states have sought Medicaid waivers for demonstration projects, most of which are placing Medicaid recipients in established managed care programs. However, the current system is far too restrictive.

The governors have proposed their own solutions to the problems of Medicaid and welfare. In general, the proposals are very similar to the House Republicans' proposals, and most Republicans are supporting the governors' agreement. However, it is not clear to what extent the entitlement status of Medicaid remains or to what extent the plan would give the states "maximum flexibility in the design and implementation of cost-effective systems of care."

Some have criticized the governors plan for ignoring the rise of illegitimacy and the collapse of the family. However, the governors have expressly stated that this is an important issue for them, they just do not want Washington dictating how they address such problems.

Overall, the governors' proposal is a step in the right direction.

STATE EXPERIMENTS UNDERWAY

In implementing Medicaid reform, Congress should be careful not to limit or restrict successful state experiments now underway.

Workfare. Although many states have adopted workfare programs, the most successful program so far is in Oregon. The welfare bureaucracy there has completely changed its orientation from a focus on "eligibility determination" to "job placement." Unlike other states, Oregon is largely ignoring job-training programs, preferring instead to put welfare recipients directly into jobs. Moreover, Oregon is proving that its approach does not cost money. Indeed, it saves money:

- Over the 1993-95 biennium, the state's welfare caseload dropped by 10.2 percent, while the caseload was rising in neighboring states.
- Since July 1995, the caseload has dropped another 8.3 percent.
- For the current biennium, the state's welfare department requested an 11.2 percent reduction (that's an absolute reduction, not a decrease in the rate of growth!) in its budget.

Of special interest is the state's JOBS-Plus Program, now being implemented in six pilot counties. Under this program, welfare recipients are eventually confronted with a choice: they can have a paycheck, but not a welfare check. So far, about 60 percent of welfare recipients have been determined to be work-eligible. And of those who have gone through the complete program, *about 80 percent leave (presumably for better private sector jobs or other options) rather than take a subsidized job.* Thus, JOBS-Plus promises even more dramatic reductions in the welfare rolls, leading to even steeper reductions in welfare spending.

Specifically, the program works like this. All employers who qualify and who currently employ 14 or fewer employees are eligible for one subsidized employee. Larger employers are eligible for more, but not more than 10 percent of their existing total employee base. In order to participate, the employer must agree not to replace any existing employees or their existing jobs with the subsidized employee, and must agree to provide a mentor. The mentor may be the owner, a manager or another employee. The employee is only temporary and is subject to the employer's rules. The job can last a maximum of six months with the same employer. Both the

employer and employee can terminate an unsatisfactory match. A local advisory board, consisting primarily of business people, effectively monitors the program.

The employer is reimbursed for the minimum wage and the employers' share of the Social Security, unemployment insurance and workers' compensation premiums by the state of Oregon, which utilizes funds that previously paid for welfare, food stamps and unemployment benefits. Employees who previously qualified for child care and medical care continue to receive those benefits paid by the state. After an employee is with an employer for 30 days, the employer pays $1.00 an hour into an educational account (administered by the state) that the employee or their family can use.

After six months in a subsidized job, the employer must offer the employee a nonsubsidized job or the employee is recycled in the program. The program is working. JOBS-Plus is placing 1,000 people per month into nonsubsidized jobs paying better than $5 per hour and sometimes as much as $8 to $10 per hour. These are not make-work jobs, but career development jobs with a promising future.

Former welfare recipients like the program because they are working, generally receiving more income, learning skills, and connecting with mainstream America. Employers like the program because they can train a potential employee with minimum expense and some additional productivity possible. Also, reimbursement forms are simple and payment is made in 10 days. Although there is no obligation to hire an individual into an unsubsidized job, many have.

The Oregon Health Plan. In 1987 the Oregon legislature decided to cancel Medicaid funding for about 30 organ transplant recipients so that the state could expand services to poor women and children and still balance its Medicaid budget. Since then, the state has been openly advocating rationing under a global budget, passing rationing legislation in the Oregon Health Plan.

In an effort to avoid the budgetary struggles that occur under rationing, the legislature created a method to include citizens in the ranking of medical treatments based on such factors as costs, benefits to the patient, the extent to which treatment would affect the patient's quality of life and community values. The original list, which consisted of 709 procedures, was a result of a first-of-its-kind public process that included public hearings, community meetings and telephone surveys. The legislature was prohibited from changing the order of the list. It could only determine how much money was available for Medicaid spending and where to draw the line on the list.

Proponents argue that the plan makes open and explicit rationing decisions that are being made covertly under the current system. Critics argue that the plan unfairly reduces care for the young, the elderly and those with terminal illnesses such as AIDS.

If we tried to meet every health care need, we could easily spend the entire gross national product on health care. As a consequence, we must choose between health care and other uses of money. One benefit of the Oregon plan is that it draws our attention to this uncomfortable fact. If government controls our health care dollars, the government must make the rationing decisions. If people control their own health care dollars, they can make their own rationing decisions.

CONCLUSION

In conclusion, I would like to say that reform of Medicaid is possible and desirable. The governor's plan is a step in the right direction. However, even more radical steps need to be taken.

PREPARED STATEMENT OF HON. ORRIN G. HATCH

(FEBRUARY 22, 1996)

Thank your, Mr. Chairman. I, too, would like to welcome the distinguished panel of Governors to our hearing today, and would like to commend them for their perseverance in developing their proposals on Medicaid and welfare reform.

As my colleagues on this committee well know, we spent a considerable amount of time, energy, and thought last year in developing a comprehensive plan to reform Medicaid and welfare only to have our proposal rejected by the President.

As I am sure you can appreciate, this process is not easy by any stretch of the imagination.

The bottomline is that comprehensive reform Medicaid and welfare are critically needed. And it's not just because the costs of these programs are out of control, but because we need to reevaluate the scope and focus of Medicaid and welfare to ensure that appropriate and cost-efficient services are provided to those truly in need.

I think the NGA proposal, which, I am proud to note, our Utah Governor Mike Leavitt had such a large hand in developing, is a good starting point. Obviously, the "devil is in the details" and I want to work closely with all of you as we develop legislation.

Let me also state there are a number of issues that I strongly believe need to be addressed adequately in any reform proposal. Two such issues immediately come to mind: (1) the impact of Medicaid and welfare reform on the government's long-standing commitment to Native Americans and (2) the need to preserve the infrastructure of community health centers and rural health clinics in any Medicaid reform.

That being said, I look forward to the testimony of our witnesses here today and I thank each of you for appearing.

PREPARED STATEMENT OF ORRIN G. HATCH

(FEBRUARY 28, 1996)

Thank you, Mr. Chairman.

Madame Secretary, I too would like to welcome you to the committee.

I have always appreciated your candor, and I appreciate that you are representing the Administration on this important issue today. I am sure we can have a good, honest dialogue about the Administration's views on these bipartisan proposals.

The issue of Medicaid and welfare reform has been one which this committee has been addressing for well over a year.

Last year, we spent a considerable amount of time, energy, and thought in developing a comprehensive reform proposal.

If there is anything we can all agree on, it is the need for reform.

And not just because the costs are out of control, but because we need to reevaluate the scope and focus of Medicaid and welfare to ensure that appropriate and cost-efficient services are provided to those truly in need.

The bipartisan proposals from the National Governors' Association have served to move the debate forward, and I commend the NGA for their hard work.

It was clear from our hearing last week that both Republican and Democratic governors made substantial compromises in reaching their agreement.

If we are going to enact Medicaid and welfare reform this year, then we must acknowledge that the only path to the Rose Garden will be through a genuine commitment to reach compromise.

That will not preclude any of us from voicing concern about specific provisions. I am sure no one is going to be totally happy with every element of the final comprehensive bill.

But, clearly, we must continue to work on reforms in these areas. I hope that the Administration is equally committed to this process.

Accordingly, I look forward to your testimony Madame Secretary, and thank you for appearing before the committee today.

PREPARED STATEMENT OF REV. FRED KAMMER, SJ

Thank you for this opportunity to testify before this Committee on the recent welfare proposal of the National Governors Association.

Catholic Charities USA is the national association of 1,400 local Catholic Charities agencies and institutions with 234,000 staff and volunteers. Catholic Charities programs served over 11 million people in 1994. People of all religions and of no religion and of every racial, social, and economic background come to us for help.

Through home health care and Meals on Wheels, we help elderly and disabled people stay in their homes and out of nursing homes.

We resettle refugees from every part of the world and help them to become productive Americans.

We sponsor affordable housing for low- and moderate-income families and individuals.

We help to form families through adoption.

We keep families together through marital and family counseling.

We reunite families through services to refugees and immigrants.

We rebuild families torn apart by substance abuse or domestic violence.

We help families get back on their feet when floods, earthquakes, fires, plant closings or downsizings leave them jobless or homeless.

And over the past 15 years, our agencies have tried to cope with a steady increase in hunger and homelessness in their communities. In 1981, fewer than one million people came to our agencies for emergency food and shelter. By 1994, that number grew to over seven million people who received emergency help, a 700 percent increase! For example, bags of groceries for 60-year-old grandmothers; firewood for elderly couples; cots in shelters for runaway abused teenagers; meals in soup kitchens for minimum wage workers.

Our agencies and their staffs and volunteers are in this work for three reasons:

(a) our Catholic religious teaching and tradition which requires reaching out to the poor and vulnerable;

(b) the shocking and painful conditions suffered by so many of our brothers and sisters; and

(c) the needs of federal, state, and local government officials to contract for services with reliable, professional, efficient, and low-cost local partners for the delivery of essential services.

Much of the work of our agencies and institutions is work that Americans recognize as traditional government functions: foster care for abused and neglected children removed by judges from their parents' homes; long-term residential care for children who are so mentally and physically handicapped that they cannot live with their families or who have no families; and residential care for severely mentally ill youngsters.

Our agencies are reimbursed by government agencies under contracts to provide services that government would otherwise have to provide. As a result, over 60 percent of the cash revenues of our local agencies come from local, state, or Federal funds. The balance is raised by the local churches and from fees paid by those who are able to pay for services.

Many people, including some Members of Congress, were stunned last year by the vehemence with which the Catholic bishops and Catholic Charities leaders rejected the welfare bills approved by the House and Senate. The opposition of Catholic leaders was not limited to a few details, but to the flawed philosophical basis of the proposals.

The opposition of Catholic Charities USA to the National Governors Association plan rests on the same principles.

In our Catholic social teaching, the whole society, including the national government, has a responsibility to foster and to protect the basic human dignity of each and every person. Government has both a moral duty and a moral function to protect human rights and human dignity and to secure justice for all. In our Catholic view of human rights and dignity, government at all levels must play key roles in assuring that jobs are available for workers and that adequate income is available to those who cannot be expected to work: the old, the sick, the disabled, and children.

As the US Catholic Bishops said in their 1986 pastoral letter, *Economic Justice for All,*

> "The responsibility for alleviating the plight of the poor falls on all members of society. As individuals all citizens have a duty to assist the poor through charity and personal commitment. But private charity and personal commitment are not sufficient. We also carry out our moral responsibility to assist and empower the poor by working collectively through government to establish just and effective public policies."

With regard to poor families, in our tradition parents have a responsibility to care for and financially support their children to the extent that they are able. And, because parents have that responsibility, they also have the right to expect that government will create the conditions under which they can fulfill their responsibility. In our American context, in a complex global economy, this means that the national government should not only use economic and monetary policy to promote full employment, but that government must ensure that adequate assistance is available to those who cannot find jobs at decent wages. Families with children should have first claim to the resources of society and government when a lack of jobs or low wages keeps them from supporting their children.

Let's look at the National Governors Association welfare reform proposal in light of this moral obligation of government to ensure that adequate support is available for children through jobs for parents or a national safety net. In our view, the National Governors Association plan, like the Congressional plan, has four fatal flaws:

(1) *It would repeal the Federal guarantee of protection for poor children, and it would allow the states to turn their backs on their obligations to poor families.*

The National Governors Association plan, like the Congressional plan, repeals the entitlement for individual children to assistance when their parents are destitute,

and it does not replace that right with a right to a job, or training for a job, or any other means for the parents to support their children.

By repealing the rights of children to Federal AFDC assistance and not replacing that right, the Federal Government would begin to treat children after they are born as Federal law now treats children before they are born, as non-persons undeserving of Federal protection of their human lives and dignity.

As you know, the Catholic Church has long supported the human life amendment which would extend the protection of Federal law to the lives of children before they are born. Just as we believe that the Federal Government should protect children from abortion, we also believe that the Federal Government should protect them from the suffering and deprivation of poverty.

(2) *The second fatal flaw in the National Governors Association plan is that it would repeal the right of individual children to receive protection against abuse and neglect by their parents and caretakers. While the National Governors Association plan is better in many respects than the 1995 House bill with regard to the child protection programs, it would still permit states to evade their responsibility to individual abused and neglected children.*

As you know, Mr. Chairman, 22 states are under court order because of their failure to have adequate staffing and other resources to protect children. Recently the New York Times reported that in New York City, city workers falsified records so as to hide the fact that children were lost in the foster care system for years without so much as a visit from a case worker to determine if the child were alive or the foster home still standing.

We would never argue against reforms in the child welfare systems, but based on our decades of experience in nearly every state, children will be much less safe if Congress repeals their Federal rights to protection.

We see these cases close up when untrained and understaffed state and local welfare departments fail to remove children from dangerous situations, fail to move for termination of parental rights to free children for adoption, and fail to give families the help they need to stay together in safety.

We get the burned and battered babies, the traumatized toddlers, and the seriously disturbed adolescents on our doorsteps, often too late to fully heal or comfort them.

Abused and neglected children are at the bottom of the priority list in state capitols. The right to go to Federal court to compel states to protect children is critically important. If you repeal that right, outrageously inept and ineffective systems will become even more dangerous to children in the majority of states. Please do not wash your hands of these children.

(3) *The third fatal flaw of the National Governors Association plan is that it retains the rigid and arbitrary time limits for welfare assistance that were included in the House bill. As you know, families could not receive cash assistance for more than 5 years (or 2 years at state option) and states would have no responsibility for providing alternate assistance or jobs for the parents.*

Let us be clear. Catholic Charities USA supports reasonable work requirements for parents on welfare so long as safe, affordable child care is available. In our teaching, work is not punishment. Work is both a right and a reward. Work is the normal way we not only support ourselves, but it is also the primary way that adults participate in God's creation and in the life of their communities.

We would like to see more emphasis on work in welfare reform, but a positive emphasis. The Governors' plan does little to foster work or to help create jobs, and it does not require states to take any action whatsoever to make sure that jobs are available.

Only a few states have pursued this path of creating jobs. Oregon, for example, with Federal waivers, is subsidizing real jobs with private employers by combining AFDC and Food Stamps benefits as subsidies for new jobs for former welfare recipients. Real jobs, real paychecks; that's real welfare reform.

Emphasizing work for parents, however, should not mean requiring single parents to work full- time, as in the Governors' plan. Children need more from their parents than financial support. We do not believe that government should set a standard of full-time work for all parents. The work of parents inside the home is also critically important.

Moreover, requiring 35 hours per week of work in exchange for a welfare check of $500 per month would make a mockery of the minimum wage and would be exploitive.

In addition, adopting rigid lifetime limits on welfare would be wrong and dangerous. Rigid and arbitrary time limits would leave millions of children with no support, no hope, and no help. We cannot understand how this Nation could deny addi-

tional welfare assistance to children whose only crime is that, after living on welfare for a total of 2 years or 5 years, their parents still can't find jobs.

Some policy-makers have argued in this room that the churches and charities will pick up the slack when welfare time limits and other budget cuts are implemented. However, the churches and charities that are in large-scale anti-poverty work (Catholic Charities, the Evangelical Lutheran Church, the Salvation Army, the Jewish Federation, Family Service America, the United Way and many others) have all disputed that notion.

Charities and religious organizations are already reeling under the combined assault of federal, state, and local budget cuts and increasing poverty and need for assistance. This Committee's recommended cuts are only one part of a big, ugly picture of anticipated cuts in food, housing, health care, and emergency services.

To get a sense of just how much "slack" the charities and religious groups would have to pick up, we divided the total amount of Federal cuts in means-tested programs for the poor by the total number of churches, synagogues and mosques that are big enough to at least have a telephone listing.

Over 7 years, the total cuts would amount to almost $2 million per religious congregation. That's $2 million more that they would have to raise (over and above what they raise now) for their buildings, staff, services and programs for the poor. It's no wonder that religious leaders across the nation have denounced this idea that they can make up for the Federal abandonment.

(4) *The fourth fatal flaw in the National Governors Association plan is that it retains the ill- advised policy denying aid to children born to teenage mothers and to mothers already on welfare. While the National Governors Association plan does not require states to adopt these dangerous polices, it would permit all states to go down this road without Federal oversight or any effort to learn what the outcome will be of these cruel policies.*

As you know, New Jersey is the only state with data on the result of a "family cap" policy. The Catholic bishops and Catholic Charities have repeatedly opposed the "family cap" on principle as well as on the empirical evidence.

Despite all the hoopla a year ago, a careful review of New Jersey's data shows only a 10 percent decline in births to welfare mothers, and no difference at all between birth rates of those subjected to the "family cap" versus those who knew they would receive additional cash payments for their additional children.

Moreover, while births to welfare mothers were declining by about ten percent, Medicaid- financed abortions for welfare mothers in the state increased by about four percent. That means that almost half of this decrease in births is attributable to some women having abortions they would not otherwise have had without a "family cap" policy.

Imagine for a moment a group of 100 mothers on welfare who might become pregnant this year. Based on the New Jersey experience, of the 100 women, only six will take effective steps to prevent conception, four will have abortions, and 90 will have children anyway who will be even poorer and more deprived than under current policies. Four children aborted, 90 children born into worse poverty, six not conceived. Is this an acceptable outcome for public policy?

While we have been disappointed that the Clinton Administration continues to grant additional state waivers for the "family cap," we are shocked that some "pro-life" Members of Congress continue to support a policy which has led to abortions that would not otherwise have occurred.

In the Catholic moral tradition, we do not believe that the ends justify the means. Reducing out- of-wedlock births is an important goal, not just among welfare mothers, but in all social and economic classes. Yet we cannot condone policies that will make some children pay with their lives in the hopes that some other children will not be conceived.

While no data is yet available on the potential impact of a ban on welfare aid to children of teenagers, our agencies have many decades of experience in helping teen parents finish school, find and keep jobs, and become good parents. We feel strongly that states should have to provide for these children but not in the form of welfare checks for teenagers. For two and one half years, we have argued for keeping teen mothers and their children eligible for welfare, but that the payment should go to responsible adults or agencies that will ensure that the teens are in school or preparing for work.

We should not allow states to forget about these very young mothers and babies. It's wrong to give them a check and leave them alone, and it's equally wrong to deny them a check and leave them alone. In our experience, most teen mothers are the victims not of passion, but of exploitation and abuse. These girls need to be rescued and protected, rather than lectured and shamed.

No institution in the United States is tougher on sex outside marriage than the Catholic Church. If there were convincing evidence that irresponsible sexual behavior could be curbed by the "family cap" or denial of aid to teenagers without causing worse problems, we would be first in line to advocate those policies.

Before closing, I would just like to say a word about assistance for immigrants. Apparently the Governors could not reach consensus on the treatment of legal immigrants in federally funded programs. In the religious community, however, I believe there is a consensus. Religiously affiliated groups that receive Federal funds are alarmed by provisions in the welfare, reconciliation, and immigration bills that would not only make immigrants ineligible for most federally-supported programs, but would require private non-profit agencies to screen their clients for citizenship and immigration status.

We can only imagine what new bureaucratic nightmares will face public agencies such as housing authorities, welfare departments and school systems if they have to make eligibility and benefit decisions based on the highly complex and confusing vagaries of immigration law. They have our sympathy for these new unfunded mandates. The immigrants, however, deserve more than our sympathy. The prospect of immigrants being deemed should concern all Americans who care about respect for the human rights of all persons. Hunger, illness, and homelessness can strike any family despite its best efforts.

We cannot imagine how local churches, charities , shelters, soup kitchens, and day care centers will be able to meet the requirements of the proposed changes in the law. How will homeless shelters or shelters for battered women turn people away because in their pitiful plastic garbage bags, containing only a few possessions, there is no birth certificate? Battered women seldom appear at our offices with any kind of documents because they are running for their lives. If we are forced to screen for citizenship or legal residence, many native-born Americans could be turned away.

Moreover, our religious traditions do not allow us to turn away people in need. From the Hebrew Scriptures through the New Testament, we are commanded to "welcome the stranger." I believe the religious groups will continue to serve immigrants through private donations; so, if the goal is to discourage illegal immigration or even legal immigration by poor people, this tool of public policy will fail.

But the necessity to hire and train staff to screen for immigration status and to keep records showing that no Federal money was used to help the ineligible immigrants and to provide separate programs will hamstring the very private agencies that Congress is relying on to help the poor. At the least, non-profits and religious groups will have to become more like the bureaucracy at the welfare departments. At the worst, some American citizens will not get the help they need because of the expense of implementing these new requirements.

There is one element of the National Governors Association plan that we can endorse wholeheartedly: limiting cuts in the Earned Income Credit to not more than $10 billion over 7 years. Scaling back both eligibility and the amount of the credit (as in the reconciliation bill) would punish the very families that can be role models for families on welfare. Our agencies work with many of those families earning $18,000 to $25,000 per year who earn too much for Food Stamps or Medicaid, don't get health insurance through their jobs, and aren't eligible for subsidized child care. These same families earn too little to take full advantage of the dependent care credit and are not eligible for the home mortgage deduction. Even with the most frugal and careful budgeting, these families are always falling behind. Cutting their EIC sends the wrong signal to them and to families on welfare, a signal that the game of life is rigged against people who work hard all their lives at low wages.

And work is the key to welfare reform

As Pope John Paul II said in his very first encyclical *On Human Work,* "Work is the key to the whole social question."

For more than a year, the welfare debate has focused almost exclusively on personal responsibility, with hardly a mention of social responsibility. The Catholic church, from the Pope on down through the bishops, teaches that government must respect and guarantee that individual rights are respected, including the right to "suitable employment for all who are capable of it," to just and adequate wages, and to social welfare benefits when jobs are not available or people are not able to support themselves and their families. Government does not have to do everything, but the national government's role is to ensure that the minimum standards are available to all: jobs, food, housing, health care, education.

This has never been more necessary or more important than now when the pressures of a global economy and a world-wide social upheaval are undermining traditional values in the marketplace as well as in the home.

Thank you for the opportunity to share our views on the National Governors Association plan. Our 1,400 local agencies stand ready to show to Members and staff of this Committee the kind of work we do and introduce you to the people we serve.

PREPARED STATEMENT OF HON. DANIEL PATRICK MOYNIHAN

Mr. Chairman: I would like to thank the Governors for their hard work and for being here this morning. The 104th Congress has devoted a great deal of attention and energy to Medicaid and welfare policy, but bipartisan agreement has eluded us thus far. Although I disagree with some of your recommendations, I commend you for endeavoring to achieve solutions that are bipartisan.

The welfare proposal agreed to unanimously by the NGA two weeks ago is quite similar to H.R. 4, the Personal Responsibility and Work Opportunity Act, which President Clinton vetoed on January 9. Like H.R. 4, your proposal would repeal Title IV–A of the Social Security Act of 1935, the Aid to Families with Dependent Children program. It imposes a time limit of five years on aid to families, while permitting states to have even shorter time limits.

What effect would these radical changes have on dependent children and their families? Sadly, we know very little about the causes of the breakdown in family structure. We do know that this is a phenomenon that exists throughout the industrialized world, regardless of differences in welfare policy among nations.

And we know that the time limit in the proposal before us would result in the termination of assistance to 2,800,000 children by the year 2005, according to newly released numbers from the Department of Health and Human Services. We know this because 76 percent of children will be on the rolls for more than five years. We also know, thanks to an analysis released in December by the Office of Management and Budget, that legislation similar to this proposal would plunge 1.5 million children into poverty.

On October 13, 1988, President Reagan signed the Family Support Act of 1988 in a ceremony in the Rose Garden. That legislation, which was the result of close collaboration with the Governors, introduced the idea that while the government has a responsibility to provide assistance to dependent children and their families, adult recipients have a responsibility to work. The bill passed the Senate on a truly bipartisan basis by a vote of 96-1. Now, less than eight years later, at a time when we have seen almost five years of sustained economic growth, we are poised to repeal the 60-year-old guarantee of support for our poor children.

How we ever got to this point is beyond me, but something new seems to have taken hold in our attitudes toward the most vulnerable individuals. For the first time in our history, we appear prepared to adopt a cruel and newly coercive kind of social policy: an attempt to coerce the poor into behavioral change by deliberately making their lives as wretched as possible. The idea is to make life for the poorest young mothers and their children so utterly miserable that they will not dare bring additional children into the world.

A recent Dear Colleague letter signed by two Members of the majority in the House of Representatives, and endorsed by the Christian Coalition, argues as follows:

> The Governors' plan is simply unacceptable. It completely misses the point of what real welfare reform is all about . . . The Contract with America contained the Personal Responsibility Act, which was the basis of legislation Congress eventually passed. The purpose of the Personal Responsibility Act was not to make welfare more efficient, or to eliminate abuse, or to create block grant programs, or even to require welfare recipients to work, although those are important objectives and the bill did accomplish them. The purpose of welfare reform in the Contract with America was to "discourage illegitimacy and teen pregnancy."

And to do that, the letter goes on to say, you must have a "mandatory family cap," meaning a ban on aid for children born to mothers on welfare. The phrase "discourage illegitimacy and teen pregnancy" has become code for some whose agenda is to punish children in order to discourage certain behavior by their parents.

The NGA welfare proposal does not mandate a family cap or cut off assistance to unwed mothers under age 18, although it does permit states to adopt these measures. And it imposes a five-year time limit on benefits. It is not clear to me why Governors would endorse a mandated time limit. To say again, new data from the Department of Health and Human Services shows that the time limit in this proposal would cut off assistance to 2.8 million children by 2005, based on CBO caseload projections. This is a conservative estimate, since it assumes that no state will adopt a time limit of less than five years, although some undoubtedly would do.

During the Senate debate on welfare last fall, I said on the floor that there would be children sleeping on grates in America if time limits were enacted. My friend Governor Chiles surely knows that in the city of Miami, 55 percent of children receive-AFDC at some point in the year. In Detroit, Governor Engler, it is 67 percent. When assistance is cut off, where will these children go?

The goal of welfare reform should not be to punish dependent children, but rather to encourage recipients to work their way off the welfare rolls. Under current law, states already have the flexibility they need to implement sweeping changes. The Administration has granted 53 waivers in 37 states. The JOBS program, put in place by the Family Support Act of 1988, is working, as the nonpartisan Manpower Demonstration Research Corporation has shown. Lawrence Mead of Princeton University testified before this Committee that

> The main effect of block grants would be to disestablish the JOBS program, which has been the major force pushing states with large caseloads to reform.

Abolishing AFDC and JOBS now, while forcing states to impose severe and arbitrary time limits, would put our nation's children at risk as never before.

Last March, this committee heard stirring testimony from Sister Mary Rose McGeady of Covenant House, a shelter program for homeless children. Her conclusion bears repeating:

> Ladies and gentleman, you must not, you cannot, abandon these children. The Federal government should not abdicate its responsibility by merely transferring it to the states. While it may sound like the perfect solution, it is not. It would not be right or just.

We should have similar concern for children on Medicaid, although I agree that we must recognize the fact that Medicaid expenditures are growing at an alarming rate, in a way that AFDC expenditures are not.

When the Medicaid program was enacted in 1965 it was modest by today's standards. In 1970 it accounted for only 1.3 percent of the Federal budget and 5.6 percent of the average State's budget. As such, the debate concerning the relative role of Federal versus State financing of the program was not seen as the life-or-death matter it has become today. Indeed, Congress merely borrowed a financing formula already on the books—from the Hill-Burton Hospital Construction Act of 1946, which allocated funds based on the square of the ratio of state per capita income to average per capita income in the United States.

What a different condition we find ourselves in today. Medicaid has grown into one of the largest budget expenditures in every State, accounting for an average of 17 percent of a State's budget—and in most States it is the only part of the budget still growing. While the program has grown, and has burdened State governments in ways hardly imagined in 1965, the funding formula has not changed. The problem of crushing State Medicaid budgets has led to more than one call for a change in the formula, but Congress has never tackled the issue. Losers always seem to outnumber winners in the zero-sum game of formula changes.

In a commencement address at Kingsborough Community College in Brooklyn in 1977, I proposed (only half-jokingly) that instead of basing Federal Medicaid payments on the square of the ratio of state per capita income to average per capita income, why not the square root? This would have narrowed the disparity in matching rates between States. I have been trying to make this point about fairness for close to two decades now; it is the subject of a report entitled *New York State and the Federal Fisc* I have put out each year since 1977, with the help of the Kennedy School of Government at Harvard.

Questions of fairness ought to be addressed now that Medicaid expenditures are such a large part of each State's budget. And with comprehensive Medicaid reform on the horizon we have little choice but to address the issue. A formula that places a fair and equitable burden on all States must be the goal. The current formula is clearly lacking in this regard.

From the first, it has been a formula designed to move more Federal funds to the South and West, out of the North and East. Again, the ratio is determined by the square of the ratio of state per capita income to average per capita income in the United States. States have received as much as an 83 percent Federal match. New York, California, some other States, get the lowest Federal match rate: 50 percent.

The most glaring inequity in the current formula is that it does not account for differences in the cost-of-living. We define poverty on a national basis, but an income of 100 percent of poverty, or any given level of poverty, in a low-cost state provides a better standard of living than it does in a high-cost State.

May I make this point? Adjusted for cost of living, New York State has the sixth highest incidence of poverty in the nation. Florida has the 20th highest.

Arkansas has the 19th highest. New York is a poorer State than Arkansas. A new idea, I grant; new data, I assert. But truth as well.

The Medicaid and welfare block grant formula fights, however, have shown that politics, and not policy, is likely to determine the outcome of any attempt to change the Medicaid formula significantly. Such a process might lead to a formula just as unsatisfactory as the current formula. Perhaps only a new, and higher, floor on the Federal matching percentage is realistic. The proposal before us should be applauded on those grounds. It raises the minimum Federal match from 50 percent to 60 percent. This will at least afford some relief to high-cost States that are penalized by the current formula.

Governors, thank you for your efforts. I look forward to your testimony.

EFFECT OF FIVE-YEAR TIME LIMIT IN GOVERNORS' WELFARE PLAN

CHILDREN ON AFDC IN 2005 UNDER CURRENT LAW (CBO)	10,200,000
CHILDREN CUT OFF IN 2005 BECAUSE OF TIME LIMIT (TOTAL)	4,896,000
BLACK (49.3%)	2,414,000
WHITE (25.1%)	1,229,000
HISPANIC (19.2%)	940,000
OTHER (6.5%)	318,000

PREPARED BY SENATE FINANCE COMMITTEE MINORITY STAFF, BASED ON INFORMATION PROVIDED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE URBAN INSTITUTE.

ASSUMES APPLICATION OF TIME LIMIT TO 100% OF CASELOAD.

FEBRUARY 27, 1996.

EFFECT OF FIVE-YEAR TIME LIMIT IN THE GOVERNORS' PLAN

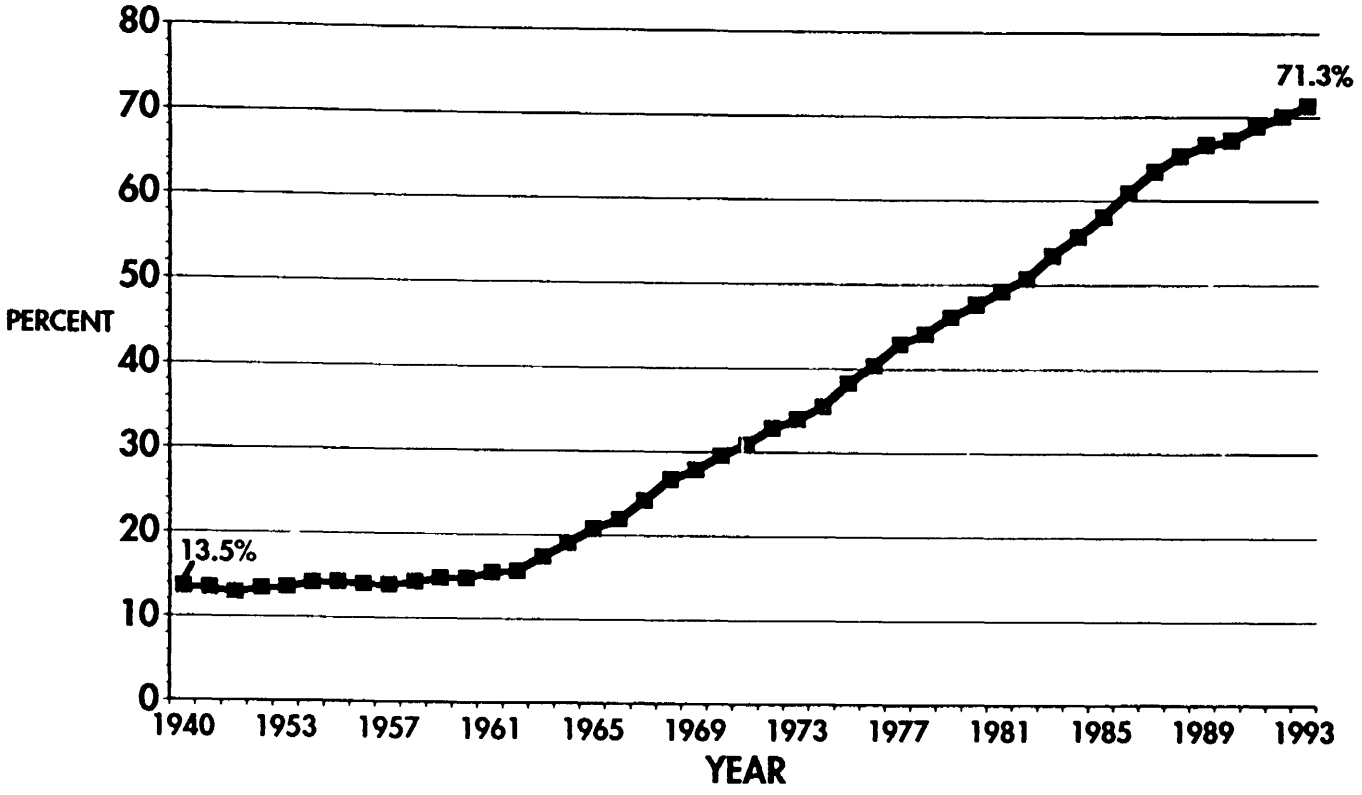
YEAR	CHILDREN CUT OFF
2001	3,552,000
2002	575,000
2003	375,000
2004	250,000
2005	144,000
TOTAL	4,896,000

PREPARED BY SENATE FINANCE COMMITTEE MINORITY STAFF, BASED ON INFORMATION PROVIDED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE URBAN INSTITUTE.

ASSUMES APPLICATION OF TIME LIMIT TO 100% OF CASELOAD, AND ENACTMENT IN 1996.

FEBRUARY 27, 1996.

PROPORTION OF BIRTHS TO TEENAGERS (AGE 15-19) THAT ARE OUT-OF-WEDLOCK (UNITED STATES)

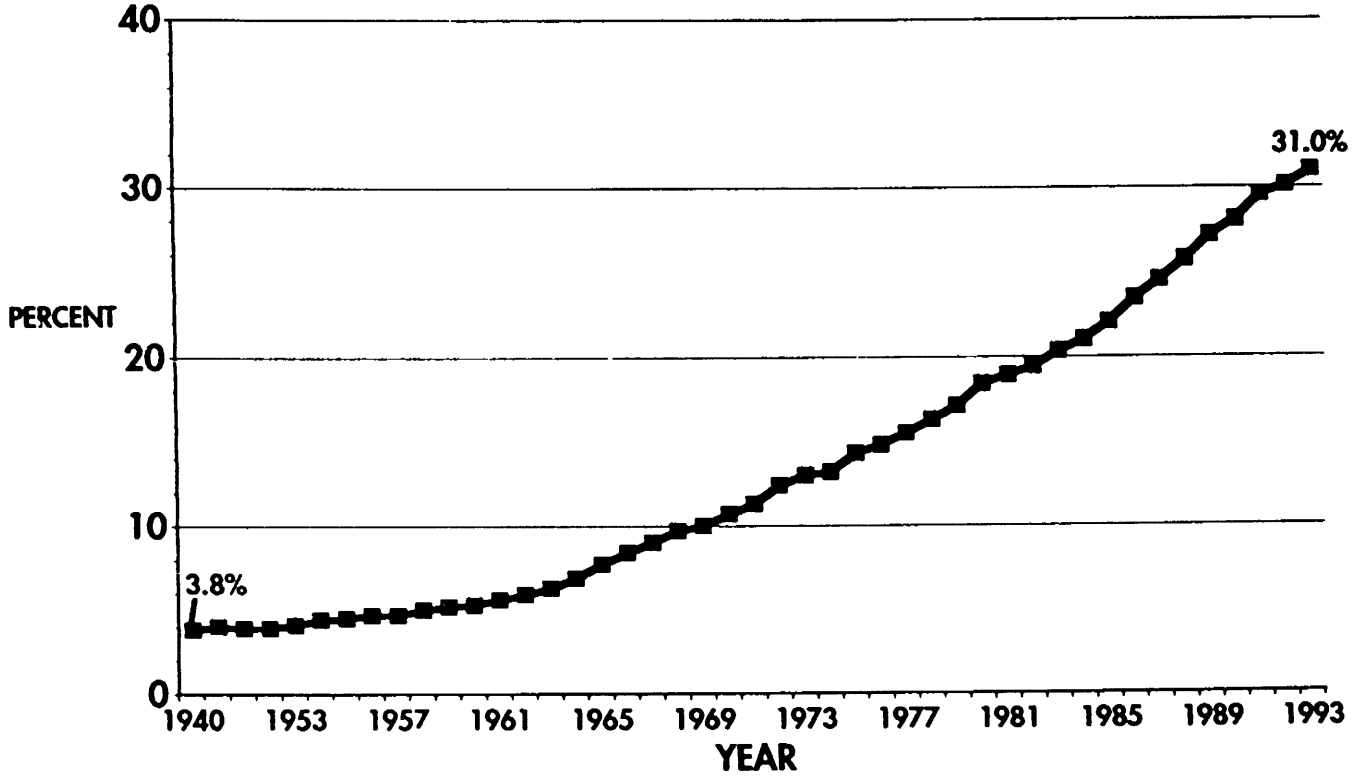


Source: Report To Congress On Out-of-Wedlock Childbearing, Department of Health and Human Services. September, 1995.

2/28/96

Births/teenagers

PROPORTION OF BIRTHS WHICH ARE OUT-OF-WEDLOCK (UNITED STATES)



Source: Report To Congress On Out-of-Wedlock Childbearing, Department of Health and Human Services. September, 1995.

2/28/96

Births/wedlock US

The New York Times

NEW YORK, SATURDAY, MAY 27, 1995

Senate Committee Approves . A Vast Overhaul of Welfare

By ROBERT PEAR

WASHINGTON, May 26 — The Senate Finance Committee approved a momentous shift in social policy today, voting to cancel the Federal guarantee of a subsistence income for poor children while giving states vast new power to design their own welfare programs without Federal standards.

By a vote of 12 to 8, the committee approved a sweeping welfare bill generally similar to one passed by the House in March. Senator Bob Packwood, the committee chairman, said the bill would reach the Senate floor next month, and he predicted that more than 60 of the 100 senators would vote for it.

The White House, while criticizing many features of the bill, avoided any veto threat. Administration officials predicted that Mr. Clinton would eventually sign a measure like the Senate bill, which would fulfill his campaign promise to "end welfare as we know it," though in ways far different from what he envisioned. Mr. Clinton never proposed ending the Federal guarantee of some minimal support for poor children, and his proposal would have spent more than would the Senate bill on programs to put welfare recipients to work.

Donna E. Shalala, the Secretary of Health and Human Services, said: "I am pleased that the legislation eliminates some of the extreme and punitive provisions in the bill passed by the House of Representatives. But it still has a long way to go on what should be the centerpiece of welfare reform — helping people earn a paycheck, not a welfare check."

Today's vote followed party lines with one exception. Senator Max Baucus of Montana, a Democrat, voted for the bill. He is up for reelection next year and is considered vulnerable. He said that the bill was good for Montana and that he trusted state officials to take care of poor people in the absence of Federal

Continued on Page 8, Column 1

Continued From Page 1

standards. .

The handling of welfare legislation illustrates how the Republican revolution that swept through the House in the first 100 days is moving at a more measured pace in the Senate. But the results are similar.

The Senate bill omits House provisions that would require states to deny cash assistance to unmarried teen-age mothers, most legal aliens and additional children born to families already receiving welfare. The Senate bill, sponsored by Mr. Packwood, would not require those restrictions but would allow the states to impose them.

Senator Daniel Patrick Moynihan, a New York Democrat who has studied welfare policy for decades, described today's vote as "a constitutional moment" in which the committee was eliminating a safety net for dependent children established by the Social Security Act of 1935. Senator Carol Moseley-Braun, Democrat of Illinois, said: "We are deciding whether or not these United States are one country or a conglomeration of 50 separate entities. Under this bill, if children wind up sleeping in the streets in one state, there is nothing that the rest of the country can do about that."

Democrats said state officials would sometimes be unable or unwilling to care for their poor. Ms. Moseley-Braun said the Federal Government had a duty to make sure children "will not go homeless or hungry, die from deprivation" or sleep on top of one another like street urchins.

But Republicans rejected that argument. Senator John H. Chafee, a moderate Republican from Rhode Island, said: "When I was Governor, one of the most sensitive issues I had before me was taking proper care of children. Governors are going to be extremely conscious of taking care of children. The fears of Senator Moseley-Braun are not justified."

The Department of Health and Human Services estimated that four million children would lose welfare benefits under a provision of the bill that would bar payments to any family for more than five years. The House bill also includes a five-year limit, and so that provision appears likely to become law.

The Senate bill, like the House bill, would eliminate any requirement for states to spend their own money as a condition of getting Federal money for cash assistance to poor people. The Finance Committee rejected a proposal by Senator John B. Breaux, Democrat of Louisiana, to require states to continue current levels of state welfare spending.

States now contribute 43 percent of the money spent on the main welfare program, Aid to Families With Dependent Children: $10 billion of $23 billion this year.

The Senate bill would sharply restrict Supplemental Security Income benefits for disabled children. The cutbacks in the House bill are somewhat deeper.

Under Senator Packwood's bill, each state would receive a lump sum, or block grant, equal to the amount of Federal welfare spending in the state in 1994. The block grants would total $16.8 billion a year from 1996 through 2000, without any adjustment for inflation or population growth. States would have to put at least half of their adult welfare recipients into jobs, training or education programs by 2001, and their Federal welfare money could be cut 5 percent if they failed to do so.

John W. Tapogna, a welfare analyst at the Congressional Budget Office, told the committee that only six states could meet the work requirements; he did not name them. To comply with the requirements, he said, states would need to spend 60 percent of their block grants, $10 billion of the $16.8 billion, on job training, education and child care. Mr. Tapogna said that 44 states would accept financial penalties rather than invest so much of their Federal money in job programs.

As a result, said Senator Kent Conrad, Democrat of North Dakota, the work requirements in Mr. Packwood's bill are hollow. Deborah V.

Supporters and opponents agree: the occasion is momentous.

Weinstein of the Children's Defense Fund said the study by the Congressional Budget Office "shows that the work requirements are an exercise in posturing."

Mr. Packwood said he was surprised to hear that 44 states could not meet the work requirements, and he said he would re-examine this part of his bill.

Unlike the House measure, the Senate bill does not make any substantial change in food stamps or the school lunch program. But on the floor next month Republican senators may propose amendments to revamp those programs too.

Administration officials said this week that President Clinton would veto any bill that replaced food stamps with block grants. But the White House has not made such threats with respect to the main cash welfare program, Aid to Families With Dependent Children.

An Administration official, speaking on condition of anonymity, said, "A.F.D.C. is the bone that the Clinton White House can throw to the hounds at the door, the people who want to make radical changes in the welfare state." The official said the White House had not made a major effort to preserve the entitlement of poor people to welfare benefits because such an effort would be "more trouble than it's worth" in political terms.

Senator Moseley-Braun said she feared that states, to avoid becoming magnets for the poor, would try to outdo one another in cutting welfare benefits if they were not required to put up any of their own money to obtain Federal dollars. But Senator Bob Dole, the Republican leader, said, "If that happens, we will be back here in a year doing the opposite of what we are trying to do today."

Mr. Dole, a candidate for the Republican Presidential nomination, said, "I don't see this as a totally partisan effort here."

Senators from fast-growing states like Florida, Texas and Arizona expressed concern because Mr. Packwood's bill would freeze allocations of Federal money, with no allowance for changes in population. Senator Kay Bailey Hutchison, Republican of Texas, sent a letter to Mr. Packwood saying the proposed formula for dividing up Federal money "would produce devastating results over a five-year period."

The letter was signed by 29 other senators from Sun Belt states, many Republicans among them.

PREPARED STATEMENT OF THE NATIONAL GOVERNORS' ASSOCIATION

RESTRUCTURING WELFARE AND MEDICAID

Thank you Mr. Chairman. We appreciate the opportunity to appear before you today to present the National Governors' Association's (NGA) Policy on Welfare Reform and Medicaid. Before we address the specifics of our policies, however, we would like to make a few general comments.

- First, Governors believe it is critical that Congress pass and the President sign the three major bills of welfare reform, Medicaid, and employment and training during the next month. States must have the ability to enact budgets that fully integrate these three programs in order to provide cost-effective services that assist in moving people from welfare to work.
- Second, Republican and Democratic Governors worked closely together to craft and pass the NGA welfare policy. To maintain the integrity of what is a strong bipartisan agreement, we believe it is imperative that the congressional process also be bipartisan. Our policy builds upon the work of Congress and adds important changes to promote work and protect children.
- Third, the welfare and Medicaid policies were passed unanimously by the nation's Governors, and therefore we have strong bipartisan support for our positions. However, that support may be withdrawn if Congress or the administration makes major changes to our proposals.
- Additionally, while we believe that we have provided you with a considerable amount of detail, we realize that there will be additional questions as you proceed toward drafting the legislation. In some areas we may be providing you with additional details. Nevertheless, we feel very strongly that the nation's Governors want to be deeply involved in working with you to develop and review legislative language. We want to do this on a strong bipartisan basis. We understand that you intend to move quickly and we are prepared to work hard to meet your schedule. It is critical, however, that we keep all Governors informed so that we will be able to support the final bill.
- Finally, we would like to say that there is an urgency that you enact this legislation over the next month. The window of opportunity is very small. Shortly, you will need to begin the budget process for fiscal 1997. Also, failure to act now means that any reform is unlikely to occur for two to three years since this is an election year. States spend on average about 25 percent of their own state money on welfare and Medicaid, and many Governors have incorporated restructured programs into their fiscal 1997 budget. The failure of Congress to move forward will cause major problems in a number of states.

WELFARE

Now we would like to present to you the National Governors' Association policy on welfare reform which was adopted with unanimous bipartisan support just two weeks ago at our winter meeting. With a unanimous bipartisan voice, the nation's Governors are asking for a new welfare system that allows us to assist individuals in moving from a cycle of dependency to self-sufficiency. We are asking you to give us the flexibility to design our own programs and the guaranteed funding we need at appropriate levels, and we will transform the welfare system into a program of transitional assistance that will enable recipients to become productive, working members of our society.

We believe that our nation's leaders are faced with an historic opportunity and an enormous responsibility to restructure the federal-state partnership in providing services to needy families. The Governors are committed to achieving meaningful welfare reform now, and we believe that Congress and the President share in this commitment. We cannot afford to miss this opportunity. Indeed, for the past year and a half, we have all invested considerable time and energy in reforming federal welfare policy.

Congress has made significant strides toward allowing states to build upon the lessons they have learned through a decade of experimentation in welfare reform. The President, too, gave impetus to welfare reform when he proposed the Work and Responsibility Act more than a year and a half ago, and he has continued to grant waivers to states to facilitate experimentation throughout the ongoing debate on welfare reform.

Today, the nations' Governors come to you with a specific list of recommendations for welfare reform that builds upon the work of both the House and Senate. We urge Congress and the President to join with us in support of this bipartisan agreement that will reallocate responsibilities among levels of government, maximize state flexibility, recreate welfare as a time-limited program leading to work, provide ade-

quate child care, and ensure that all parents assume responsibility for their children.

The NGA policy builds upon and improves the framework for welfare reform laid out in the H.R. 4 conference agreement to the Personal Responsibility and Work Opportunity Act. The conference agreement contains many elements of welfare reform supported by the Governors.

- It defines welfare as a transitional program leading to self-sufficiency and provides time-limited cash assistance to beneficiaries.
- It recognizes that the best work requirement is a private sector job but that subsidized jobs and community service are appropriate in some instances.
- It provides guaranteed and predictable funding with a contingency fund for states' cash assistance programs during periods of economic downturn.
- It allows flexibility for states to expand programs to encourage family stability and reduce teen pregnancy. It provides flexibility for states to design their own benefit levels, eligibility criteria, and earned income disregards in their cash assistance program
- It supports improved child support enforcement efforts, particularly for interstate cases.
- It permits improved coordination and conformity between a state's cash assistance program and the Food Stamp program.

We are very pleased that the conference agreement contains so many provisions that reflect our concerns and priorities and we applaud the progress you have made. However, in order for the nation's Governors to support the H.R. 4 conference agreement, we believe further changes must be made based largely on the following principles:

- Welfare reform must foster independence and promote responsibility.
- Children must be protected throughout the restructuring process.
- States must be protected during periods of economic distress.
- Given agreement on broad goals, states must not be subject to overly prescriptive standards.

The welfare reform policy adopted by the National Governors' Association includes specific recommendations to address these concerns. They are outlined below.

Funding for Child Care

The Governors propose an additional $4 billion in mandatory spending for child care for the fiscal 1997 through fiscal 2002. This funding would be part of the base funding for child care and would not require a state match. The Governors are strongly united in their belief that adequate child care is a critical component in the success of any welfare-to-work effort. In fact, access to child care is by far the number one barrier to independence. Our experience has shown us that without safe and reliable child care, a young mother will not be able to participate in employment training, find work, or keep a job. The Governors believe that the current funding provided in the H.R. 4 conference agreement is not sufficient to meet the child care needs of welfare recipients engaged in work activities, individuals who are transitioning from welfare to work, and those who are at-risk of going onto welfare. Without additional commitment from the federal government for child care, states may be forced to choose between providing child care for the working poor or providing child care for welfare recipients.

Work Requirements

The Governors propose greater flexibility in meeting the work participation requirements. Prescriptive and narrowly drawn requirements will hamper the states' ability to design work programs that are appropriate to their unique economic situation. We have several recommendations in this area.

- First, the Governors believe strongly that when states are successful in moving individuals from cash assistance to work, these individuals should be included in the work participation rate calculation as long as they remain employed. Discounting these individuals from the work participation rate seems contradictory to the goals of welfare reform.
- Second, the number of hours of participation required for purposes of meeting the work participation rate in future years should be 25 hours a week, rather than the proposed increase to 30 and 35 hours a for single-parent families and the 35 hour participation requirement for two-parent families. Further, states should be given the option to limit the required hours of work to 20 hours a week for parents with a child below age six. Many states will, in fact, set higher hourly requirements, but this flexibility will enable states to design programs that are consistent with local labor market and training opportunities and the availability of child care. Lowering hourly requirements for families with young

children is also consistent with broader trends in society where a large proportion of women with young children are working part-time.

- Finally, in the work area, the Governors propose that job search and job readiness be allowed to count as a work activity for up to twelve weeks, rather than just in the first four weeks of participation. States have found that job search is not only effective when a recipient first enters the program, but also after the completion of individual work components and placements.

Contingency Fund

The Governors propose that an additional $1 billion be added to the contingency fund for state welfare programs. We believe that states should have access to additional federal matching funds during periods of economic downturns and increases in unemployment or child poverty. During these times, some states may not have the fiscal capacity to meet increases in demand for assistance without an additional financial commitment from the federal government. Given the historical volatility of the caseload throughout economic cycles and the difficulty in projecting future changes in the economy, we believe the additional $1 billion is necessary.

Our policy also calls for the addition of a second trigger option in the contingency fund that would allow a state to qualify for the fund if the number of children in the food stamp caseload increased by 10 percent over fiscal 1994 or fiscal 1995 levels. This trigger is meant to serve as a proxy for increases in child poverty. The 75 percent maintenance-of-effort requirement for the cash assistance block grant applies to the contingency fund and a state would draw down contingency funds on a matching basis.

Performance Bonuses

The Governors' proposal includes performance incentives in the form of cash bonuses to states that exceed specified employment-related performance target percentages. We believe that it is appropriate to reward states that have high performance. However, these bonuses would not be funded out of the block grant base but would receive separate, mandatory funding.

Flexibility

The NGA Welfare Reform Policy also contains a number of specific proposals to lessen some of the prescriptive requirements in the bill, while also adding flexibility and accountability.

- It provides states with the option to restrict benefits to additional children born or conceived while the family is on welfare. A family cap should not be a federal requirement that would require state legislative approval to opt-out.
- It sets the administrative cap on child care funds at 5 percent. The 3 percent contained in the conference agreement is not realistic.
- It raises the hardship exemption from the five-year lifetime limit on federal cash benefits to 20 percent of the caseload.
- It adds a state plan requirement that the state set forth objective criteria for the delivery of benefits and for fair and equitable treatment with an opportunity for a recipient who has been adversely affected to be heard in a state administrative or appeal process.

Child Welfare

In the area of child welfare, we believe that we have developed a proposal which protects children while allowing states the flexibility to focus greater effort on successful prevention efforts such as family preservation. Our proposal would replace Title VII in the H.R. 4 conference agreement.

- First, the Governors' policy would maintain the open-ended entitlement for foster care and adoption assistance maintenance, administration, and training as under current law.
- Second, the policy would create a Child Protection Block Grant, consolidating funding for the remaining child welfare, family preservation, and child abuse prevention and treatment programs. As you know, these programs are not currently individual entitlements. States must maintain protections and standards under current law.
- Finally, states would have the option of taking all of their foster care and independent living funding as a capped entitlement (or block grant) and would be allowed to transfer any portion of the these funds into the Child Protection Block Grant for activities such as early intervention, child abuse prevention, and family preservation. States must continue to maintain their effort at 100 percent based on state spending in the year prior to accepting the capped entitlement. Again, states must maintain protections and standards under current law.

SSI for Children

With respect to Supplemental Security Income (SSI) for children, the Governors propose to adopt the provisions in the Senate bill that eliminate the comparable severity test and the Individualized Functional Assessment (IFA) for determining eligibility for children. Only children who meet or equal the Medical Listings of Impairments will qualify for SSI. We do not support the two-tiered payment system that was contained in the H.R. 4 conference agreement. We would also set an effective date for current and new applicants of January 1, 1998.

Food Stamp Program

In the Food Stamp Program, our policy would reauthorize the program in its current uncapped entitlement form. We also propose to modify the income deductions as outlined in the Senate-passed welfare bill, which achieves savings through modifications to the standard deduction rather than capping the excess shelter deduction. Governors voiced concerns that the changes to the excess shelter deduction in the H.R. 4 conference agreement would disproportionately impact the very poorest and families with children.

Child Nutrition

In the area of child nutrition, we propose changes to the School Nutrition Block Grant Demonstration that would be authorized in seven states. Within these demonstrations, our policy would maintain the current entitlement for children, and schools would continue to receive per-meal federal subsidies for all lunches and breakfasts under current eligibility criteria. States would, however, receive their administrative dollars as a block grant. There are two final areas our policy addresses—territories and the Earned Income Tax Credit.

Territories

The Governors strongly encourage Congress to work with the Governors of Puerto Rico, Guam, and the other territories toward allocating equitable federal funding for their welfare programs.

Earned Income Tax Credit

And finally, while the Earned Income Tax Credit (EITC) may be considered in the context of budget reconciliation rather than welfare reform, the Governors believe that the availability of the EITC to low-income families is critical to ensuring that a family is better off working than on welfare. The Governors' policy would limit the budget savings from revising the EITC to $10 billion. We also believe a state option should be added to advance the EITC.

Benefits for Aliens

The absence of recommendations on the restriction of benefits for aliens should not be interpreted as support for or opposition to the alien provisions of the H.R. 4 conference agreement. It is likely that you will be hearing directly from Governors that have concerns in this area.

MEDICAID

Mr. Chairman and members of the committee we would now like to turn our attention to Medicaid policy which like the Welfare Reform policy was adopted unanimously on February 6. This is a most important time. Our charge as elected officials is difficult. Americans expect discipline in federal and state spending, and we have the responsibility to assure that the funds we spend are spent wisely and that they produce a cost-effective return on investment. In no area is such a need greater than in publicly funded health care.

Background

For most of the last decade, health care expenditures in the United States have far exceeded overall growth in the U.S. economy. And while medical inflation is declining, public and privately funded health care costs continue to limit the long term economic growth of the nation. For states, the primary impact of health care costs on state budgets has been in the Medicaid program. Annual Medicaid growth over the last decade has been well in excess of 10 percent, and in half of those years annual growth approached 20 percent. Determining the causes of such unbridled growth is difficult. However, major contributing factors include: congressional expansions in the program, court decisions limiting the states in their ability to control costs, policy decisions by states maximizing federal financing of previously state-funded health care programs, and changing demographics. Restricting the growth of Medicaid is no easy task. Medicaid is the primary source of health care for low income pregnant women and children, persons with disabilities, and the el-

derly. This year, states and the federal government combined will spend more than $150 billion in this program providing care to more than 35 million people. The challenge for the nation, and Governors as the stewards of this program, is to redesign Medicaid so that health care costs are more effectively contained, those that truly need health care coverage continue to gain access to that care while giving states the needed flexibility to maximize the use of these limited health care dollars to most effectively meet the needs of low income individuals.

The New Program

Within the balanced budget debate, a number of alternatives to the existing Medicaid program have been proposed. The following outlines the NGA proposal. It blends the best aspects of the current program with congressional and administration alternatives toward achieving a streamlined and state-flexible health care system that guarantees health care to our most needy citizens. Since the proposal was unveiled on February 6th, we have had a myriad of questions concerning the details of the proposal. Some of those questions have been answered others remain unresolved. It is not our intent today, to put forth a completed proposal with all of the "I's" dotted and "T's" crossed. Rather, this is an outline and a working document that is meant to be refined through a process of public examination.

Program Goals. The NGA proposal is guided by four primary goals.

- The basic health care needs of the nation's most vulnerable populations must be guaranteed.
- The growth in health care expenditures must be brought under control.
- States must have maximum flexibility in the design and implementation of cost-effective systems of care.
- States must be protected from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics and natural disasters

Eligibility. Coverage remains guaranteed for

- Pregnant women to 133 percent of poverty.
- Children to age 6 to 133 percent of poverty.
- Children age 6 through 12 to 100 percent of poverty.
- The elderly who meet SSI income and resource standards.
- Persons with disabilities as defined by the state in their state plan. States will have a funds set-aside requirement equal to 90 percent of the percentage of total medical assistance funds paid in FY 1995 for persons with disabilities.
- Medicare cost sharing for Qualified Medicare Beneficiaries.
- Either:
  —Individuals or families who meet current AFDC income and resource standards (states with income standards higher than the national average may lower those standards to the national average.); or
  —states can run a single eligibility system for individuals who are eligible for a new welfare program as defined by the state.

Consistent with the statute, adequacy of the state plan will be determined by the Secretary of HHS. The Secretary should have a time certain to act. Coverage remains optional for:

- All other optional groups in the current Medicaid program.
- Other individuals or families as defined by the state but below 275 percent of poverty.

Benefits. The following benefits remain guaranteed for the guaranteed populations only. Inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening, Diagnosis and Treatment Services. (The "t" in EPSDT is redefined so that a state need not cover all Medicaid optional services for children.)

At a minimum, all other benefits defined as optional under the current Medicaid program would remain optional and long term care options significantly broadened. States have complete flexibility in defining amount, duration, and scope of services.

Private Right of Action. The following are the only rights of action for individuals or classes for eligibility and benefits. All of these features would be designed to prevent states from having to defend against suits on eligibility and benefits in federal court.

- Before taking action in the state courts, the individual must follow a state administrative appeals process.
- States must offer individuals or classes a private right of action in the state courts as a condition of participation in the program.

- Following action in the state courts, an individual or class could petition the U.S. Supreme Court.
- Independent of any state judicial remedy, the Secretary of HHS could bring action in the federal courts on behalf of individuals or classes but not for providers or health plans.

There should be no private right of action in federal court for providers or health plans.

Service Delivery. States must be able to use all available health care delivery systems for these populations without any special permission from the federal government. States must not have federally imposed limits on the number of beneficiaries who may be enrolled in any network.

Provider Standards and Reimbursements. States must have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan. The Boren amendment and other Boren-like statutory provisions must be repealed. "One hundred percent reasonable cost reimbursement" must be phased out over a two year period for federally qualified health centers and rural health clinics. States must be able to set their own health plan and provider qualifications standards and be unburdened from any federal minimum qualification standards such as those currently set for obstetricians and pediatricians. For the purpose of the Qualified Medicare Beneficiaries program, the states may pay the Medicaid rate in lieu of the Medicare rate.

Nursing Home Reforms. States will abide by the OBRA '87 standards for nursing homes. States will have the flexibility to determine enforcement strategies for nursing home standards and will include them in their state plan.

Plan Administration. States must be unburdened from the heavy hand of oversight by the Health Care Financing Administration. The plan and plan amendment process must be streamlined to remove HCFA micromanagement of state programs. Oversight of state activities by the Secretary must be streamlined to assure that federal intervention occurs only when a state fails to comply substantially with federal statutes or its own plan. HCFA can only impose disallowances that are commensurate with the size of the violation.

This program should be written under a new title of the Social Security Act.

Provider Taxes and Donations. Current provider tax and donation restrictions in federal statutes would be repealed. Current and pending state disputes with HHS over provider taxes would be discontinued.

Financing. Each state will have a maximum federal allocation that provides the state with the financial capacity to cover Medicaid enrollees. The allocation is available only if the state puts up a matching percentage (methodology to be defined.) The allocation is the sum of four factors: base allocation, growth, special grants (special grants have no state matching requirement) and an insurance umbrella, described as follows:

1. *Base.* In determining base expenditures, a state may choose from the following—the 1993 expenditures, 1994 expenditures, or 1995 expenditures. Some states may require special provisions to correct for anomalies in their base year expenditures.
2. *Growth.* This is a formula that accounts for estimated changes in the state's caseload (both overall growth and case mix) and an inflation factor. The details of this formula are to be determined. This formula is calculated each year for the following year based on the best available data.
3. *Special Grants.* Special grant funds will be made available for certain states to cover illegal aliens and for certain states to assist Indian Health Service and related facilities in the provision of health care to Native Americans. States will have no matching requirement to gain access to these federal funds.
4. *The Insurance Umbrella.* This insurance umbrella is designed to ensure that states will get access to additional funds for certain populations if, because of unanticipated consequences, the growth factor fails to accurately estimate the growth in the population. Funds are guaranteed on a per-beneficiary basis for those described below who were not included in the estimates of the base and the growth. These funds are an entitlement to states and not subject to annual appropriations.

Populations and Benefits. Access to the insurance umbrella is available to cover the cost of care for both guaranteed and optional benefits. The umbrella covers all guaranteed populations and the optional portion of two groups*persons with disabilities and the elderly.

Access to the Insurance Umbrella. The insurance umbrella is available to a state only after the following conditions are met.

1. States must have used up other available base and growth funds that had not been used because the estimated population in the growth and base was greater than the actual population served.

2. Appropriate provisions will be established to ensure that states do not have access to the umbrella funds unless there is a demonstrable need.

5. *Matching Percentage.* With the exception of the special grants, states must share in the cost of the program. A state's matching contribution in the program will not exceed 40 percent.

6. *Disproportionate Share Hospital Program.* Current disproportionate share hospital spending will be included in the base. DSH funds must be spent on health care for low income people. A state will not receive growth on DSH if these funds constitute more than 12 percent of total program expenditures.

Provisions for Territories. The National Governors' Association strongly encourages Congress to work with the Governors of Puerto Rico, Guam, and other territories towards allocating equitable federal funding for their medical assistance programs.

Conclusion

We believe that the that we have presented before you today are sound. We encourage you to give them most careful consideration as you continue your deliberations. Thank you Mr. Chairman and members of the committee for giving us the opportunity to appear before you today. We are happy to answer any questions.

PREPARED STATEMENT OF HON. LARRY PRESSLER

Welfare and Medicaid reform are two of the greatest issues before this Congress. They are issues the people of South Dakota are interested in. I thought we had two excellent reform plans come out of the Senate and Conference. The President's failure to sign Congress' welfare reform bill was very disappointing.

I commend the National Governors' Association for stepping in to keep these issues alive and bring us closer to enactment of reform. I support many of the provisions included in the NGA proposals. The National Governors' Association has provided us a chance for real reform—it would be a shame to let it slip away.

I would like to take this opportunity to express my disappointment in the Administration's failure to recognize the importance of the NGA's proposed Medicaid "special grants" provision, specifically, the NGA's inclusion of grant funds for Indian Health Service and related facilities in the provision of health care to Native Americans. Coming from a state in which 35 percent of its Medicaid beneficiaries are Native Americans, this provision is of great interest to me.

Additionally, I have several concerns about the Governors' welfare proposal I would like to address. Foremost, I am concerned about attempts to weaken work requirements. The greatest change we are trying to affect is to turn welfare from a handout to a program that rewards work and self-sufficiency. We are attempting to end the "free lunch" mentality. Any reductions in the work requirement move us backward, not forward. I am concerned about increasing amount of job search time that could be counted as work and I am concerned about reducing work participation rates in future years. Where I come from, work means an honest day's labor, not opening a newspaper to scan the classified ads. We must instill real work in the welfare system, not a watered-down substitute.

I want to consider these issues carefully as part of the NGA package and I hope my colleagues will join me in this effort. We need to work towards a system that promotes personal independence and wellness, ensures efficiency and value, and reinforces accountability and responsibility.

PREPARED STATEMENT OF HON. DAVID PRYOR

Mr. Chairman, thank you for holding this series of hearings on the National Governors Association (NGA) proposals for reforming our Medicaid and Welfare programs. I am pleased to have the opportunity to hear testimony this morning from our distinguished Secretary of Health and Human Services, Secretary Shalala. I look forward to her valuable input as we evaluate these proposals.

I would like to congratulate the Governors for the bipartisan nature of their work. I am hopeful that Congress can further develop these proposals in the same bipartisan fashion. I appreciate the Governors willingness to continue working with those of us on both sides of the aisle to add details to this proposal, and to craft legislation that a majority of us can support.

MEDICAID

As with any new legislative proposal, many unresolved issues remain. This morning I would like to touch on two specific areas of concern in the Medicaid proposal—coverage for long-term care and prescription drugs.

The NGA proposal to restructure the Medicaid Program raises a number of concerns with respect to nursing home standards and coverage. The Governors have stated that they wish to retain the nursing home quality standards enacted in the 1987 Omnibus Budget Reconciliation Act (OBRA 87). However, it appears they would repeal the Federal provisions to enforce these standards and turn enforcement over to the States. Without Federal enforcement, I am afraid these so-called "Federal" standards would amount to nothing more than a hollow promise.

Also, the NGA proposal has some missing pieces with regard to coverage of long-term care. It appears that many individuals who are now eligible for Medicaid coverage of nursing home care could lose that coverage. Also, there seem to be no clear guarantees that adult children will not be held responsible for the cost of their parents' nursing home care.

Although it is not specified in their proposal, it is my understanding that the NGA may recommend that the Medicaid drug rebate program be a voluntary option for the states. Of course, it is hard to imagine any state would carelessly forego its share of the $12 billion which the CBO projects will be earned in rebates over the next seven years. Finally, we should also ensure that states enjoy equal flexibility in establishing their own supplemental rebates or other financing mechanisms.

WELFARE

I do have a number of concerns about the Governor's welfare proposal, concerns that we can work together to solve. First, the Governors proposal raised the funding level of the contingency fund, but eliminated the maintenance of effort provisions. I do not think states should be able to reduce their contribution and then expect the federal government to pay more in times of crisis. When we give states more flexibility in administering their welfare programs, they should also share the responsibility for these programs. The additional $4 billion in child care funds should also be subject to some form of matching requirement.

Another area of concern is the provision that will allow states to switch between a child protection block grant and the current system on a yearly basis. Although we do not want to lock states into a child protection block grant that they find unworkable, allowing states to switch back and forth so readily is not the answer. I know other Senators share my concern and I am sure that we can work with the Governors to find an acceptable solution.

Mr. Chairman, we have a huge challenge ahead of us as we review these proposals. I again commend you for holding this series of hearings. I look forward to the testimony this morning.

PREPARED STATEMENT OF ROBERT D. REISCHAUER

Mr. Chairman and members of the Committee, I appreciate this opportunity to discuss the governors' Medicaid restructuring proposal with you. The governors should be commended for their constructive effort to craft a plan that represents a compromise between the MediGrant approach contained in the Balanced Budget Act and the capped per-capita grant approach endorsed by the Administration. The governors' proposal responds to the widely recognized need to reform Medicaid in order to reduce the federal deficit, ease the unrelenting pressure that Medicaid has placed on state budgets, and provide states with the flexibility they need to design and operate programs that are both more efficient and better reflect each state's particular circumstances. In addition, the governors' proposal recognizes the need to ensure that any restructured Medicaid program should guarantee that certain vulnerable groups continue to have access to the basic health care services that the current Medicaid program provides.

The governors' proposal cannot be fully evaluated at this time because only a six page outline description of the plan is available. Many critical details remain unspecified and these details will be crucial for determining the proposal's ultimate impacts. Nevertheless, even the general description of the plan that is available suggests several areas for concern. I will focus my remarks on four of these, the loss of guaranteed coverage for certain groups, the possibility that the services provided for guaranteed groups may be inadequate, the magnitude of the reduction in overall resources available for health services for the poor, and the possibility that the plan

will fail to protect states adequately from fiscal repercussions of unanticipated economic and demographic developments.

ELIMINATING GUARANTEED COVERAGE FOR CERTAIN GROUPS

Certain groups that are currently guaranteed Medicaid coverage would lose this protection under the governors' proposal. At present, state Medicaid programs are required to provide benefits to cash assistance recipients (AFDC and most SSI), pregnant women and children under six living in families with incomes below 133 percent of the poverty guideline, and children born after September 30, 1983 who live in families with incomes below the poverty guideline. In addition, state Medicaid programs are required to pay Medicare part B premiums and cost sharing (deductibles and co-payments) for poor Medicare participants and part B premiums for Medicare participants with incomes between 100 percent and 120 percent of the poverty line.

At their option, states can also extend Medicaid coverage to other groups and receive federal matching payments for the expenditures made on their behalf. These groups include, among others, pregnant women and infants with incomes between 133 percent and 185 percent of the poverty guideline, individuals receiving state supplementary SSI cash payments but not federal SSI benefits, the "medically needy" who are people who do not meet the financial standards for cash assistance but meet the nonfinancial standards and have incomes and resources within state-established limits, and certain institutionalized people.

Under the governors' proposal some of the groups who currently are guaranteed Medicaid coverage will lose this assurance. Among the affected groups are poor children between the ages of 13 and 18 for whom guaranteed Medicaid coverage is to be phased-in over the 1997 to 2002 period under current law, aged and disabled Medicare participants with incomes between 100 and 120 percent of poverty whose Part B premiums are now paid by Medicaid, disabled SSI recipients who would not meet the new state disability definitions that would replace the federal SSI criteria that are currently used to determine which disabled individuals must be extended Medicaid coverage, and children and parents who currently are eligible because they receive AFDC or are in transition off of AFDC but who would not meet the new standards states adopt for non-aged cash assistance recipients.

While some states might choose to continue to cover some of these groups, there will be no financial incentive for them to do so for groups other than the disabled and elderly because a state's federal payment would not be affected by the number of such individuals the state chose to cover. Under the governors' proposal, states also are likely to pare back their coverage for groups whose eligibility is currently optional because the federal government will no longer share the costs of providing benefits to these groups. In effect, the price a state must pay—that is, the amount of its own money a state must spend—to provide such coverage will at least double. This will lead states to reduce their effort on behalf of these groups and shift resources to other state priorities. The resultant drop in coverage might be offset somewhat by the new flexibility states will have to design inexpensive, very basic benefit packages and their ability to offer differing coverage to different groups. Nevertheless, the governors' plan, like the MediGrant proposal in the Balanced Budget Act and many other Medicaid reform proposals, is likely to lead to a significant reduction in the number of people covered by Medicaid and a concomitant increase in the ranks of the uninsured. Considering the economic and demographic trends which most experts believe will reduce the prevalence of employer-sponsored insurance, this should be cause for concern.

THE ADEQUACY OF BENEFITS

Under the current Medicaid law, states are required to provide a specified package of services to those who are guaranteed coverage. This package includes inpatient and outpatient hospital services, physician services, laboratory and x-ray services, nursing facilities services, family planning services, early and periodic screening, diagnosis and treatment (EPSDT) services for those under 21, and other services. These services must be sufficient in amount, duration, and scope to reasonably achieve their purposes, cannot be limited because of illness type, and must be generally comparable across all mandatory groups. States can, however, impose reasonable limits on these services such as restrictions on the number of physician visits permitted during a year. In addition to the mandatory services, states can elect to provide any of a wide array of optional services such as prescription drugs, vision and dental care, occupational therapy, and hospice care.

The governors' proposal would continue the same required services for guaranteed groups with the very significant exception of certain treatments in the EPSDT com-

ponent. However, states would be given "complete flexibility in defining amount, duration, and scope of services." This flexibility opens up the possibility that a state could offer what is, in effect, a skeletal benefit package of required services to certain guaranteed groups thereby undermining the value of the protection afforded by their mandatory status. While some increased flexibility with respect to service standards is probably unavoidable and appropriate if Medicaid is to be scaled back, some minimum standards should be maintained. These standards could be uniform across the states or set with reference to the amount, duration, and scope-of-service limits contained in the average employer-sponsored health plan in each state. If the latter approach was adopted, special national standards would have to be developed for services such as long term care that are generally not covered by employer-sponsored plans.

The governors' plan could also result in the evisceration of Medicaid protection provided to Qualified Medicare Beneficiaries (QMB) with incomes below the poverty line. Currently, Medicaid pays the deductibles and coinsurance amounts they owe using Medicare payment rates. For example, if Medicare's payment rate for an intermediate physician office visit in a certain city is $50, Medicare will pay 80 percent of that rate ($40) leaving the balance, the coinsurance amount, the responsibility of the Medicare beneficiary. For QMBs, Medicaid is required to pick up the $10 coinsurance amount.

Under the governors' proposal, states would be able to substitute their own Medicaid payment rates to calculate the deductible and coinsurance amounts that Medicaid would be responsible for. Many states set their Medicaid payment rates well below those of Medicare. For example, in 1993 all but four states had Medicaid payment rates for a new patient office visit (level 3) that were below Medicare's fees; in 25 states these rates were less than 80 percent of Medicare's rates which is Medicare's payment amount; New York's Medicaid fee was only 21 percent of Medicare's. If states choose to use their Medicaid payment rates, low-income Medicare beneficiaries could find themselves liable for significant out-of-pocket costs. Using the previous example, any state's Medicaid program with a payment rate of $40 or below for an intermediate physician office visit would not be required to pay any of the coinsurance amount. If the legislative language requires that providers accept Medicaid rates as payment in full, some providers will decide to stop serving QMBs thereby reducing their access to care as well as increasing their out-of-pocket costs.

THE LEVEL OF OVERALL RESOURCES

Any Medicaid reform that contributes to reducing the federal deficit and relieves the pressure that this program puts on state budgets will reduce the overall level of public resources devoted to providing health services for low-income populations. Most of the attention on this score has been focussed on the magnitude of the reductions in federal Medicaid spending from baseline levels. Under the MediGrant proposal in the Balanced Budget Act, federal spending would be reduced $133 billion (14.4 percent) during the 1996 to 2002 period and $50 billion (26.4 percent) in 2002 from the baseline levels. The President's skeletal fiscal 1997 budget proposes reductions of $59 billion (6.4 percent) over the 1996 to 2002 period and $19.4 billion (11.2 percent) in 2002.

The governors did not stipulate a specific amount by which federal Medicaid spending would be reduced under their plan. Since the governors' proposal is a compromise effort, one can assume that their goal is to achieve federal savings over the 1996 to 2002 period that are somewhere between the $59 billion proposed by the Administration and the $85 billion figure contained in the latest Republican offer.

In many ways, the reductions in state spending that would occur under the various reformed Medicaid systems are of greater significance than the reduction in federal resources. Medicaid reform proposals differ greatly in the flexibility they give to the states to reduce their own contributions to this program. At one extreme are approaches that allow states to reduce their efforts no more than proportionally to the reduction in federal resources; in other words, if federal spending was cut by 12 percent, states could choose to cut spending from their resources by up to 12 percent. A pure block grant, under which states are not required to put up any of their own money as a condition for receiving federal assistance, represents the other extreme.

The governors' proposal maintains the existing requirement that states match, with their own resources, the payments they receive from the federal government. Under the current arrangement, the each state has its own matching rate or FMAP (federal medical assistance percentage) that is based on its per-capita personal income relative to the per-capita personal income for the nation. The share of benefit

expenditures paid for by the federal government is higher for states with low per-capita incomes than for states with higher incomes.

Although the governors' plan retains the matching requirement, it makes three modifications to current policy that will allow states to reduce their own contributions to Medicaid disproportionately relative to the reduction that will occur in federal Medicaid spending. As a result, the federal share of the total burden for providing health services to Medicaid-eligible populations will rise from its current level of roughly 57 percent.

The first and least significant of the modifications called for in the governors' plan that will lead to a reduction in state effort is the establishment of new special grants that will help pay for the health care services received by illegal aliens and Native Americans. These grants, which will be distributed only to certain states, will not have to be matched. Currently, expenditures on behalf of these groups are part of the regular Medicaid program and must be matched with state funds. Affected states, therefore, will be able to reduce their relative effort without losing any federal assistance.

The second and most significant modification that would lead to disproportionate reductions in state spending on Medicaid under the governors' proposal is the provision that would increase the minimum FMAP to 60 percent. Currently, the formula used to calculate each state's FMAP is constrained by a maximum value of 83 percent and a minimum value of 50 percent. For 1996, the federal government's share ranges from 78.08 percent for Mississippi, the nation's poorest state, to 50 percent for the twelve states with highest per-capita incomes.

The FMAP change proposed by the governors would affect 25 states in 1996, allowing them to reduce their state spending on Medicaid by a larger percentage than the reduction in federal spending without it affecting the amount they receive from federal government. The states that would be afforded this fiscal relief at the expense of their Medicaid beneficiaries and service providers are, by and large, states with above-average fiscal capacities as measured by the Advisory Commission on Intergovernmental Relations. They already benefit from the minimum values established for the FMAP. For example, without the current 50 percent minimum Connecticut's FMAP would be 18.36 percent and New Jersey's would be 25.06 percent.

If the states with current FMAPs below 60 percent took full advantage of the fiscal flexibility afforded them by the governors' proposal, the reduction in total Medicaid spending could be substantial. The Center on Budget and Policy Priorities using CBO estimates of baseline Medicaid spending and Urban Institutes estimates of the distribution of that spending across the states has calculated that states could, in the extreme, reduce their own spending over the 1996 to 2002 period by between $134 billion and $145 billion if the minimum level of the FMAP was raised to 60 percent. The lower figure assumes that federal Medicaid spending is reduced as much as the President has proposed; the higher figure assumes federal Medicaid spending at the levels of the latest Republican proposal.

The governors' proposal contains a third modification to current policy that would allow states to reduce their contribution to Medicaid without affecting their federal payments. This is the restitution of provider tax and donation practices which, before they were curbed by legislation enacted in 1991, some states used to transform federal Medicaid dollars into general state fiscal relief. In its most simple form, a state could provide its hospitals with a $100 million increase in Medicaid disproportionate share (DSH) payments. If the state had a 50 percent FMAP, $50 million of the payment would be paid by the federal government and the state would have to come up with the remaining $50 million. If the state collected $75 million from a newly imposed provider tax on the hospitals that received the higher DSH payments, the hospitals would be $25 million better off than they were before the DSH/tax scheme was in place and the state would have $25 million that it could divert to other state priorities. The federal Treasury would have paid completely for the state's fiscal relief and the hospitals net increase in resources.

Under the governors' proposal there is no danger that tax and donation schemes will increase federal spending because the aggregate size of the basic grant allocated among the states will be fixed. Nevertheless, states will be able to use such schemes to reduce the amount of state resources needed to draw down their federal grants.

Even without the three modifications I have discussed, the governors' plan will significantly reduce the pressure Medicaid places on state budgets. Considering the relative conditions of state budget, which are relatively healthy, and the federal budget, which is in need of substantial adjustments, it is not appropriate to have states capture the lion's share of the fiscal relief provided by Medicaid restructuring. If greater sacrifice is to be extracted from beneficiary populations and providers, the proceeds of that sacrifice should be shared proportionately between the federal and state governments or the federal government should be provided the larger share.

INADEQUATE PROTECTION FROM UNANTICIPATED INCREASES IN PROGRAM COSTS

Under the current Medicaid program states know that when their program costs increase unexpectedly because a natural disaster or an economic downturn expands the number of participants or unexpected inflation pushes up service costs, the federal government will pick up a sizable portion (equal to the FMAP) of the unanticipated costs. There is no limit on the amount the federal government will pay. Under the block grant approach of the Balanced Budget Act's MediGrant title, states would have to bear the entire burden of unanticipated cost increases by themselves because the amount devoted to the program would be fixed and would not respond to changes in costs or caseloads. While some of the elements in the MediGrant allocation formula might benefit states that experience unanticipated economic or demographic shocks, this assistance would be inconsequential for at least two reasons. One is that the measures of caseload need and costs—the number of poor state residents and the state's per-recipient spending—would be three year moving averages the most recent data for which would be at least a year old. Another is that floors and ceilings override the needs-based allocation formula and will constrain the sizes of the grants received by most states.

The governors' proposal seeks to protect states "from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters" through a mechanism labeled "the insurance umbrella." This mechanism would provide each state with additional funds if the estimate of the state's caseload used to allocate the block grant was lower than the actual caseload of groups guaranteed coverage plus optional portions of the elderly and disabled populations. These payments would be on a per-beneficiary basis, would reflect the state's spending for both mandatory and optional services on these groups, and would be an open-ended federal entitlement.

The insurance umbrella would effectively protect states from the unanticipated costs associated with short-run surges in their caseloads like that caused by Hurricane Andrew which temporally added 12,000 people to the Medicaid rolls in Dade County, Florida. It also could provide initial protection from unanticipated caseload increases associated with an extended economic slowdown or some unexpected, secular demographic change. But this protection would fade after a year because what was unanticipated caseload growth in one year would become part of the anticipated caseload level that HCFA used in the next year to allocate the basic block grant amount. The added caseload would then be reflected in the following year's fixed block grant to the state but it would disappear from its insurance umbrella calculation. While states whose estimated rates of caseload growth exceeded the national average would gain, their gain would be at the expense of states with less-than-average caseload growths whose shares of the basic grant would shrink.

Furthermore, the insurance umbrella would provide no protection from unanticipated systemic increases in medical costs. If medical costs were pushed up by several percentage points because unexpected and expensive new diagnostic procedures and treatments became available, the amount states received from the federal government through the basic grant and insurance umbrella components of the governors' plan would not change.

The governors' objective of protecting states and vulnerable populations from cost increases associated with unanticipated economic and demographic and natural disasters is an appropriate one. But to do this effectively, the size of the basic block grant must be allowed to vary with economic, demographic and technical conditions. The plan should lay out explicitly the expected growth in the guaranteed populations and the projected growth in national per-capita medical costs that were assumed when the size of the block grant was set for each future year. If growth in the guaranteed caseload or costs deviate from these assumed rates, the amount distributed through the block grant should be adjusted accordingly through some defined mechanism.

CONCLUSION

The governors' proposal is a work in progress. It has moved the debate forward in a constructive direction but there is a long way to go before the complex issues involved in Medicaid restructuring are resolved in an acceptable fashion. I have focussed my testimony on several areas of concern that arise from the general description of the plan. There are others including the possibility that quality assurance for both managed care and nursing homes might be compromised and that the proposal does little to equalize the wide disparity in federal payments that now exists.

As the governors specify the details of their plan, some of the problems may disappear. But many more will arise when decisions are made about specific elements of the plan. It will take weeks of hard work and analysis to resolve these complex

issues. The task is too important to be rushed to accommodate deadlines created by the need to pass debt ceiling or appropriation legislation.

RESPONSES OF MR. REISCHAUER TO QUESTIONS SUBMITTED BY SENATOR ROTH

There is little likelihood that state actions will increase the federal government's Medicaid costs substantially under the NGA Medicaid proposal. The fundamental reason why this is the case is that the total amount distributed to the states through the major element of the plan, the block grant, would be fixed for each year. State actions will affect the fraction of that fixed total that each individual state receives but will not affect the total amount the federal government distributes to all states. The umbrella payment portion of the NGA plan would expose the federal government to an open-ended commitment to fund Medicaid but this exposure would be limited because additional payments would be made only for unanticipated growth in the guaranteed population groups, persons with disabilities, and the elderly. If, as the proposal states, the block grant distribution formula is recalculated each year using the best available data, the umbrella payments will increase federal costs only temporarily and by a limited amount even if there is an unexpected secular increase in the caseload.

- Under the NGA plan, each state would have the freedom to set the eligibility standard that would determine which of the state's disabled individuals were covered under its Medicaid program. If, in some year, a state decided to institute a more liberal disability standard, its actions would lead to a temporary increase in federal spending under the NGA proposal because the state's caseload for that year would be higher than was anticipated when its block grant allocation was determined. This would trigger an umbrella payment to the state for that year. Once the liberalized definition of eligibility was in place, however, HCFA would include the resulting increase in caseload in its estimates of the caseload factor used to allocate the next year's block grant payment. The umbrella payment for the state would then disappear. The state's share of the total block grant amount, however, would increase somewhat but the total amount distributed among all the states by the federal government would not increase. The state which liberalized its disability standard would gain basic block grant resources at the expense of those states that did not loosen their eligibility.
- The federal government may experience some indirect fiscal impact if states are allowed to determine the eligibility standards for disabled participants in the Medicaid program. If states, on average, set much higher standards than now exist, some additional cost pressures may be felt in the Medicare, veterans health, and prison health programs. This effect is likely to be small because few of those disabled individuals who would lose their Medicaid coverage would be eligible for assistance from these other programs.

Looking beyond the fiscal effects, it would be a step backward to allow states complete flexibility to set eligibility standards for the disabled under Medicaid. Under current policy there is a uniform minimum standard based on SSI eligibility. It makes no sense to have a uniform national minimum standard for income support (SSI) and fifty state standards for medical assistance for the disabled. Medical care is as important to the disabled as income support and national minimum standards are appropriate. A bifurcated approach would create confusion and inequities. Some states, to save money, would set their standard very low to make their state inhospitable to disabled populations.

- The incentives inherent in the NGA approach will cause states to reduce their Medicaid spending from their own resources below the levels that would otherwise occur. This will not result in any greater direct financial drain on the federal Treasury because a reduction in state effort would not affect the amount distributed through the block grant or the umbrella payment mechanism unless a state reduced its effort so much that it did not spend sufficient amounts to draw down all of its block grant or umbrella allocations. If this happened, the federal government would save, not spend, money. Nevertheless, the NGA proposal provides states with excessive potential for fiscal relief. The states should not be allowed to reduce their spending for Medicaid disproportionately compared with the reduction in federal spending. In other words, if federal spending is cut by 10 percent, states should not be allowed to reduce their spending by more than 10 percent. If that were required, the fiscal relief afforded by the NGA proposal would be equitably shared between federal and state taxpayers.
- The freedom the NGA proposal affords states to establish provider tax and donation programs would not lead to the abuses of the late 1980s and early 1990s when federal Medicaid spending soared as a result of these schemes without there being a commensurate increase in spending on medical services for low-

income persons. Under the NGA plan, there would be little chance that reestablishing these programs would cause federal Medicaid spending to rise. These programs, however, could be used to reduce the amount of state resources needed to draw down the entire federal Medicaid grant available to a state. In other words, these programs could be used to provide fiscal relief to the states or free up state Medicaid money for spending on other services. For example, while a state may be nominally required to match each federal dollar with one of its own, provider tax and donation schemes could be used to effectively reduce the state matching rate from 50 percent to 25 percent.

- If the federal financial commitment is fixed or relatively fixed, as it is under the NGA proposal, states can be given a great deal of flexibility to determine eligibility and service levels without there being a danger that the federal Treasury will be at risk. If the federal financial commitment is open-ended, as it is under the current Medicaid program, limits must be placed on eligibility and service levels if federal spending is to be contained.

But in determining appropriate policy for Medicaid eligibility and service levels consideration should be given to other important dimensions besides the fiscal one. Within a single nation, there should be some minimum standards established for a program for which the federal government pays a majority of the costs. The mobility of the population also argues for some degree of uniformity across the states. On the other side, the diversity that characterizes the United States suggests that some state flexibility is appropriate. States should be permitted to adopt eligibility standards and benefit packages that are more liberal than the national minimums to reflect the particular circumstances and preferences of each state. The federal contribution, if any, for the additional costs associated with programs that are more generous than required by the national minimums should be proportional to the benefit to the national that derives from the more generous program.

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV

I appreciate having the Governors here today to explain and answer questions about their bipartisan proposal on welfare reform and Medicaid.

Upfront, I want to commend the National Governors Association for taking a bipartisan approach—I think that it is essential and should be a model for us here in Congress.

If we really want meaningful—workable reform—that can be signed into law (instead of just a campaign issue), we must use a bipartisan process.

I am ready to roll up my sleeves and work hard—just as we on the Finance Committee did in 1988 when we enacted the Family Support Act. I was a conferee and remember how tough those negotiations were. But there was bipartisan give and take—both sides were in the room, negotiating point by point. And the ultimate result was a truly bipartisan bill that was signed into law and has had modest, but meaningful success.

On welfare, I believe that we can and should do more to move families from welfare to work. But to make this successful, it takes more than time-limits and punitive measures. Parents need to help to get jobs and they need safe, reliable child care so they can work.

And in any discussion of welfare reform, I believe it is vital to remember that two-thirds of the people on welfare are innocent children. And I strongly believe that we have a special obligation to ensure that children are protected. This is why I will have many questions about the proposals for block grants of child welfare. These are fundamental, federal commitments to protect children from abuse and neglect.

And on the issue of Medicaid, I appreciate the goals of the NGA. We need to guarantee basic health care for our most vulnerable populations. We need to control growth in health care expenditures. We need to protect states from the unanticipated effects of economic downturn, changing demographics, and natural disasters.

We also need to give states more flexibility in the design and implementation of cost-effective systems of care—but not at the expense of accountability. We must ensure that federal funds are used to provide quality, humane and adequate health care.

The Medicaid program paid states almost $90 billion in FY 95. It would be irresponsible for the Congress to turn that amount of money over to the states with "no strings attached." Yet, the NGA proposal would cut almost all federal ties to the operation of the Medicaid program except the ties to the federal treasury.

I understand why Governors like such an approach—I was a Governor once. But as a member of the Senate Finance Committee, I want to make sure that we give an insurance card to individuals instead of an ATM card to Governors.

So I have many questions and concerns to raise at this hearing. Poor children and families in West Virginia and across our country depend on these programs for health care, food and basic necessities. We need to be careful and thoughtful in our approach to reform—we owe children and our most vulnerable citizens at least that much.

PREPARED STATEMENT OF LOUIS F. ROSSITER, PH.D.

RESTRUCTURING MEDICAID

Comments on the Governor's Proposal

Changing Cost Shifting As We Know It

Mr. Chairman and members of the committee, thank you for inviting me here today. My remarks are those of a university professor who has been a very close observer for the last 13 years of the remarkable changes in state Medicaid programs. I have had the honor of successfully competing for grants and contracts from federal agencies totaling $15 million and serving as a principal investigator of numerous federal studies of the role of competition in the financing and delivery of health care. My research has focused primarily on the Medicare risk-contract program, but I was also the principal senior researcher for the study of the cost impact of Medicaid managed care programs in California, Missouri, New York, New Jersey, and Minnesota.[1] These early Medicaid experiments in state flexibility were known as the Nationwide Medicaid Competition Demonstrations. I am responsible for the research which has led to the oft quoted figure that Medicaid managed care can save approximately 5 - 8 percent for the states. We also found Medicaid managed care offers great potential over unbridled fee-for-service for better access to care and improved coordination of care.

In my opinion, you can trace the governors' request for flexibility to these early experiments. They were found to achieve many of the goals we all seek for Medicaid -- access to care at an affordable price for the most vulnerable in our society -- thus they were replicated. The Medicaid Competition Demonstrations spawned similar managed care contracting programs in virtually every state. At least seven states have received federal approval to convert their entire state Medicaid program to managed care and cover more uninsured people in the process – Delaware, Florida, Minnesota, Hawaii, Kentucky, Massachusetts, Tennessee, Washington, Oregon, and Rhode Island, and Vermont. Maryland and California recently received HCFA approval for phasing the bulk of Medicaid recipients in their states to managed care. This wave of conversion, in my opinion, induces the governors to come to you at this time and seek unprecedented flexibility in the way they run their programs.

It is as though the states have been operating with a learners permit since 1983, and now the governors have voted unanimously to be allowed to drive by themselves.

State Flexibility

Much is made of this state flexibility. Is state flexibility merely political rhetoric? Why flexibility?

Having spent time in the Office of the Administrator, Health Care Financing Administration, I can say that there is probably more willingness to grant waivers to the Medicaid program rules than most observers assume. Medicaid Directors can use the federal rules as a convenient excuse to their governors for the bureaucratic awkwardness of their own state agencies when making explanations for delays and difficulties.

But there is something to be said for state flexibility. The need for flexibility arises, of course, from the differences in local medical care markets and the inherent differences in history, attitudes, and resources in each state. There are enormous differences among the states. For example, employer group health insurance coverage is more common in New England, Middle Atlantic, and East North Central regions. Thus, as welfare is converted to workfare, transitional health care as people move from Medicaid to employer coverage should be easiest in these regions compared to others with much lower rates of employer-based coverage. By the same token, Medicaid coverage is more common in the East South Central and Pacific regions than elsewhere. For example, Medicaid insures 15.8 percent of Mississippi's population compared to 4.8 percent of New Hampshire's. Obviously the issues of health coverage for low income people are different in these two states.[3]

Preservation of the Federal Medicaid Entitlement

The governors' proposal has certain categories of people who are guaranteed eligibility. As was the case from the start of the program, pregnant women and children, up to defined poverty thresholds, are guaranteed eligibility. Certain elderly are guaranteed. Certain persons with disabilities are guaranteed. While some governors would like to have complete relaxation of these federal guarantees, from a politically practical standpoint it is difficult to imagine any state eliminating coverage for virtually any of these groups. States trying to eliminate coverage in the absence of this entitlement would create cost shifting problems for their state. Cost shifting occurs when uncompensated care is provided and the cost of that care is shifted to paying patients. States could disadvantage themselves economically if they became known for their cost shifting problems from a skimpy Medicaid program.

Certain services are covered in the governors' proposal, but far fewer than currently covered in Medicaid. Although there are certain services that are optional today, for example, drugs, which could be optional also under this

proposal. But most state programs already cover drugs. Several states even have drug programs that exceed the federal allowable limits for drug coverage. Thus, we might not expect much to change from adoption of this part of the governors' proposal. Just as you face political pressures to cover more; state legislators and governors face such pressures and tend to respond.

Continued Federal Financial Responsibility

There are several reasons for and against continued federal financial participation in Medicaid. In favor of a continued federal role is that the federal government can serve as a moderating influence on fiscal trends in the states. The burden of Medicaid can be more evenly shared with an eye toward ability to pay across states. The power of the federal government to generate revenue can be put to work through federal financial participation.

Against a continued federal role is the notion that traditionally the states have been involved in the provision and regulation of health services (since colonial times in my state). Even today, the states regulate health insurance, professional licensure, and have enormous financial interests in health care through their Medicaid programs and state employee health benefit programs. A phased restructuring that eliminates the federal government makes some sense for a service such as health care that is so firmly rooted in local provision and regulation.

The formula-driven approach to this issue in the governors' proposal strikes a reasonable balance. It protects the federal treasury from the state tax and donation schemes in the early 1990s. It offers federal assistance, especially in times of need for the states.

Changing Health Care Cost Shifting As We Know It

Perhaps the most important aspect of the governors' proposal is that it allows the states to move toward new payment systems for care. The federal Medicaid program was established as a fee-for-service approach to improve financial access to care for low income people. Today, fee-for-service is fast declining in the private sector and is being replaced by more global payment systems. What prepaid payments per person per month accomplish that nearly 30 years of fee-for-service Medicaid has not, is to unmask the basic flaws in the current cost shifting approach to access to care. A system that permits the costs of care for Medicaid and uninsured people to be merely passed on to other payers is not a system. Allowing the states to redesign Medicaid with new payment systems largely based on prepaid approaches that suit the local needs and circumstances of the health care market in each

state will unveil the major inequities created by the current system. We can see vividly how this can work by examining the experience of states such as Tennessee, Minnesota, and Oregon.

The states have often been called laboratories. But in this case the experiments are ready to move from the laboratory to practice. With most states already creating their own managed care contract arrangements, meeting their circumstances and their needs, we have reached the point where the studies are completed and the experimental results are in. The answer is that Medicaid managed care can work.

Indeed, the access to care issues that plagued fee-for-service Medicaid programs with few participating providers have been replaced by reports of marketing abuses by managed care companies. Traditional providers who have served the Medicaid population complain they are left out of the loop as patients enroll voluntarily or involuntarily in managed care plans and change their usual source of care with the new choices patients have available. Very high cost patients with special needs are rightfully concerned that there will not be enough money in the long run to provide their care, although this is a long-standing issue for Medicaid.

On the other hand, the experience of Medicare, heading toward 4 million beneficiaries enrolled in HMOs, and the experiments to date with enrolling chronically-ill groups in managed care plans shows that it can be done. States must establish clear quality of care expectations, assess the quality, and continuously improve the quality; as we have done in Virginia.[3] But the direction for Medicaid is clear. It is time to move forward on this front and give the governors' what they request.

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[1] Freund, D., L. Rossiter, P. Fox, L. Heinen, J. Meyer, R. Hurley, T. Carey, and J. Paul. "Evaluation of the Medicaid Competition Demonstrations." Health Care Financing Review 11, 2 (1989) 81 - 97. LuAnn Heinen, Peter D. Fox, and Maren D. Anderson, "Findings from the Medicaid Competition Demonstrations: A Guide for States". Health Care Financing Review 11, 4 (Summer 1990) 55 - 68.

[2] Colin Winterbottom, David W. Liska, Karen M. Obermaier, State-Level Databook on health Care Access and Financing. Washington, D.C., Urban Institute Press, 1995

[3] Marsha Gold and Suzanne Felt, "Reconciling Practice and Theory: Challenges in Monitoring Medicaid Managed-Care Quality," Health Care Financing Review, 16, 4 (Summer 1995) 85 - 105. Virginia Department of Medical Assistance Services, Quality Assessment and Improvement Project for Medicaid Managed Care, Annual Report for Fiscal Year 1994-95, November 1995

PREPARED STATEMENT OF HON. WILLIAM V. ROTH, JR.

Let me begin today's hearing by thanking all of the Nation's Governors for the extraordinary contribution they have made which has rekindled the hope of achieving Medicaid and welfare reforms this year. All of the men and women who serve as the chief executives of our 50 States deserve our thanks and congratulations for presenting the American people with this unanimous, bipartisan proposal.

But the gentlemen whom we welcome before the committee today have earned special recognition for their efforts. It is these Governors, Carper, Chiles, Engler, Miller, Romer, and Thompson, along with Governor Mike Leavitt, who truly created this proposal when few believed it was possible.

These Governors serve in large States and small, States from the North and South, East and West. It would have been easy for them to allow politics and individual interests to divide them. Instead, they put their reputations on the line when it would have been safe to simply leave the task for someone else. Even though the President has vetoed welfare reform twice in the past few months, the Governors are united in their steadfast position that welfare reform is necessary now. Quite simply, the Governors believe that, "continuation of the current welfare system is unacceptable." If we are ultimately successful in enacting Medicaid and welfare reform, students of politics and government will long be studying this work as one of the most important legislative victories in the last quarter of the 20th century.

The Governors are here today because they realize their task was not completed on February 6 when they unanimously approved their bipartisan resolutions on Medicaid and welfare reform. Nor does their work end with today's hearing. They recognize their responsibilities in transforming the legislative process in order to restructure the welfare system has just begun. There is still much work to do in translating the ten pages of the resolutions into a comprehensive legislative package. There are tough questions which must be answered for Republicans and Democrats alike.

Most important, the Governors fully realize that the transfer of power from Washington back to the States will be contested. The NGA resolutions on Medicaid and welfare reform represent fundamental changes to a welfare system which will cost more than $2.4 trillion over the next seven years. We clearly need the continued strength and influence of this bipartisan group if we are to succeed in getting welfare reform signed into law this year which reverses the flow of power between Washington and the States.

On the major welfare issues, the NGA work reflects the fundamental changes to the welfare system advanced by H.R. 4, the "Personal Responsibility and Work Opportunity Act of 1995." The NGA proposal demonstrates we have been on the right track.

The Governors' proposal on Medicaid reminds us that Medicaid reform is welfare reform. Medicaid is the nation's largest welfare program. Each year, it costs more than the AFDC program, Food Stamps, and Supplemental Security Income program combined. As such, Medicaid must take its place in the efforts to end the cycle of dependency for the millions of American families and children now trapped in the welfare system. The current Medicaid and welfare systems are laden with perverse incentives. All too often we hear that poor families cannot afford to leave the welfare system. Therefore, Medicaid must be part of the solution for returning families to work. If we succeed in reforming our welfare programs, I believe one of the most exciting developments we will witness is how the States will use the power of Medicaid dollars to expand health insurance coverage for more working families even while slowing the rate of growth in the cost of the program.

I also believe the Governors can reassure the elderly and disabled populations that there is nothing to fear from this bipartisan proposal. It has been the States which have been active in promoting home and community-based care. It has been the States which have protected the dignity of so many by helping individuals stay with their families. Devolution of authority will improve the coordination and quality of services. It is the States which deliver services and the States therefore are in a superior position to protect the interests of people.

The work of the Governors means a fresh start for the Congress and the President. They have given us bold proposals, strengthened by unanimous support. I look forward to working with the Governors and each of my colleagues on the committee individually and collectively to deliver the authentic welfare reform the American people need and expect.

PREPARED STATEMENT OF HON. DONNA E. SHALALA

Mr. Chairman, Senator Moynihan, and members of the Committee: I want to thank you for giving me the opportunity to testify today about the National Governors' Association (NGA) resolutions on Medicaid and welfare and the President's vision for reform in these areas.

Throughout the years, this committee has built a great tradition of bipartisan leadership on these issues. We look forward to working closely with you to reach bipartisan consensus on Medicaid and welfare reform legislation.

This hearing comes at a critical juncture in our nation's history. Right now, from kitchen tables to the halls of Congress, we are engaged in a historic debate about the size, scope, and role of the federal government.

This debate is about much more than deficits and devolution. At its heart, it's about who we are as Americans—and what kind of legacy we want to leave for our children.

The Clinton Administration believes that we must balance the budget in seven years and shift more responsibility to the states and local communities. But, we must do it in a way that is consistent with our values.

As the President has said time and time again: We can balance the budget and find common ground—without turning our backs on our values, our families, and our future.

We believe we can give the states the flexibility they need—while still maintaining a strong federal-state partnership built on a foundation of shared resources, accountability to the taxpayers, and national protections for the most vulnerable Americans.

That's why the President has proposed a common sense plan that balances the budget, gives new flexibility to the states, and reforms welfare and Medicaid, without breaking our promises to our citizens—from the seniors living in nursing homes to the families struggling to break free from the chains of poverty.

That is the challenge we must meet as we work to reform Medicaid and welfare. That is the standard by which we must judge any reform, including the resolutions recently adopted by the National Governors' Association.

We greatly appreciate the efforts of the NGA in fashioning a bipartisan consensus on the foundations of a plan and their ongoing work to add further detail to their resolutions. We believe that they have made a positive contribution to the debate and have increased the likelihood that Republicans and Democrats will produce bipartisan solutions to reforming our welfare and Medicaid programs. While we applaud their tenacity and their contributions, we do have serious questions about some of the proposals they have put forward: questions about maintaining national objectives and the federal-state partnership necessary to achieve them.

It is now up to this Administration and this Congress to build on the spirit of the Governors' efforts. It is time for all of us to work together to reach our mutual goals: flexibility for the states; incentives for AFDC recipients to move from welfare to work; the preservation of health insurance coverage for those who need it most; and protections for our most precious resource, our children.

MEDICAID

Let me turn first to the Medicaid program. Medicaid provides vitally important health and long-term care coverage for 36 million Americans and their families, including the following:

- It provides primary and preventive care for 18 million low-income children;
- It covers 6 million individuals with disabilities—providing the health, rehabilitation, and long-term care services that would otherwise be unaffordable for these individuals and their families;
- It covers 4 million senior citizens—including long-term care benefits that provide financial protection for beneficiaries, spouses, and the adult children of those requiring nursing home care.
- Finally, it pays the Medicare premium and cost sharing for low income seniors, which is the only way to make the use of Medicare benefits affordable for these individuals.

As part of his balanced budget plan, the President has proposed a carefully designed and balanced approach to Medicaid reform. His plan preserves Medicaid (title XIX of the Social Security Act) but makes important changes that will give states unprecedented flexibility to enhance the program's ability to meet the needs of the people it serves. The President's plan:

- preserves the federal guarantee of a congressionally-defined benefit package for Medicaid beneficiaries;
- preserves Medicaid protection for all currently eligible groups;

- maintains our shared financial partnership with the states as they provide health coverage to needy individuals;
- provides unprecedented new flexibility so that states can better manage their programs and pay providers of care and operate managed care and other arrangements without unnecessary federal requirements, while maintaining programmatic and fiscal accountability; and
- contributes federal savings to the balanced budget plan through the use of a per capita cap on federal matching that adjusts automatically to changes in state Medicaid enrollment, changes in the economy and reductions in disproportionate share hospital payments.

As you know, the President strongly opposed—and ultimately vetoed—the congressional approach to Medicaid reform because it did not meet these standards. The Congress voted to repeal the Medicaid program and replace it with a new "Medigrant" program that did not include meaningful guarantees of eligibility or benefits. The Congress also proposed a "block-grant" funding mechanism that breached the 30 year federal partnership with the states to share in changes in state Medicaid spending.

As I mentioned earlier, NGA recently approved the outlines of its own Medicaid reform plan, which has been helpful to the debate. In particular, we have been pleased that the Governors appear to agree with one of the key elements of our plan—namely that federal financing must be responsive to actual, and often unanticipated, changes in Medicaid enrollment in the states and changes in the economy.

However, while the details of the NGA plan are still not completely fleshed out, we are concerned that the elements of the NGA resolution do not reflect the priorities set out in the President's Medicaid plan in certain areas. These are: (1) the need for a real, enforceable federal guarantee of coverage to a congressionally-defined benefit package; (2) appropriate federal and state financing; and (3) quality standards, beneficiary protections, and accountability.

The federal guarantee of coverage and benefits

The federal "guarantee" of coverage and benefits is at the core of the federal Medicaid program. Unfortunately, the term "guarantee" has been assigned very different meanings in the context of the current Medicaid debate. When we use the term guarantee in the context of a federal statute like Medicaid, we mean a real guarantee, composed of three interrelated components: definitions of (1) eligibility; (2) benefits, and (3) enforcement.

Eligibility

Let's begin with eligibility. The NGA plan sets out a number of current law groups that states must cover in their plan. However, problems remain in the NGA definition. First, it repeals the current law phase-in of Medicaid coverage for children ages 13-18 in families with income below the federal poverty level—a bipartisan coverage expansion signed into law by President Bush.

In addition, the NGA resolution repeals the federal standard for defining disability and replaces it with 50 separate state definitions. This has the effect of making Medicaid coverage and benefits for those with disabilities uncertain and variable around the nation. For example, it would be possible for states to use restricted definitions of disability resulting in very limited coverage for populations whose service needs are pronounced and among the most costly. In such situations, we are concerned that narrow state definitions of disability could preclude individuals with HIV, certain physical disabilities, or mental illness, from receiving critically needed services under Medicaid. We should not turn back the clock on those with disabilities by permitting 50 different state definitions for purposes of Medicaid coverage.

It appears that the Governors have retained the linkage between cash assistance and eligibility for Medicaid. However, there are still some outstanding questions that require clarification, including how currently covered populations, like the welfare-to-work eligibles, will be covered after the enactment of welfare reform.

Benefits

Eligibility is only one component of the guarantee—because the question is eligibility for what—bringing us to benefits. The NGA resolution lists benefits that are characterized as "guaranteed for the guaranteed populations only." The resolution also says that all other benefits defined as optional under the current program would remain optional, and that there would be an additional set of long-term care options.

This new framework raises several unresolved questions. The first relates to the adequacy of the benefits. Current Medicaid law and regulations already give states substantial flexibility in defining the amount, duration, and scope of benefits, and states have used this flexibility to respond to their unique circumstances. This lati-

tude is tempered by a very reasonable constraint—benefits must be "sufficient to reasonably achieve their purpose". We have concerns that by specifying "complete" flexibility on amount, duration, and scope, the NGA proposal provides no standard against which to assess the reasonableness of a state's benefit plan. Without a standard, any federal "guarantee" is illusory. We believe the Governors understood this as they acknowledged in their testimony last week that the provision in their resolution on this issue has shortcomings that need to be addressed.

The NGA resolution also is silent on the current law standards of comparability and "statewideness" of services—among and within eligible groups—for mandatory as well as optional services. In the absence of further information about such provisions, there is no standard against which the "guaranteed" benefits and potential discrimination against certain groups or diseases can be assessed, and therefore we are concerned about the potential for discrimination against certain groups or diseases.

The NGA proposal also would limit the treatment portion of the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program, so that states need not cover all Medicaid optional services for children. The NGA does not yet specify exactly how this would be done, so it is difficult to assess the impact of the provision—other than the certainty that some children would not receive treatments despite the clinical recommendations for those services arising from the EPSDT screening and diagnosis process.

Enforcement

The third essential component of the federal guarantee is enforcement. Implicit in the concept of defined populations and defined benefits is the notion of a meaningful enforcement mechanism. A federal cause of action for beneficiaries assures that those seeking a remedy for the deprivation of medical care receive the same due process rights everywhere in the United States. The NGA resolution requires states to provide a state right of action, but eliminates any federal right of action for individuals and providers who assert that a state is violating federal Medicaid laws. The only access to federal court for such claims would be the opportunity to petition the U.S. Supreme Court for review of a decision of a state's highest court.

The NGA provisions pose a number of serious questions and concerns. Under the proposal, we believe Medicaid would be the sole federal statute conferring benefits on individuals with no possibility of federal enforcement by its intended beneficiaries.

Review by federal courts also promotes efficiency. As a practical matter, common sense tells us that those aspects of the Medicaid program that are common to all states should be subject to consistent interpretation and administration. When the same question arises across multiple jurisdictions, decision-making in the federal court system maximizes efficiency and predictability. This is particularly true when Medicaid interacts, as is often the case, with other federal statutes (such as Medicare, Social Security, SSI and AFDC). Federal courts are more experienced in analyzing these federal programs and are better able to understand and decide cases involving relationships among them. When courts are being asked to interpret statutory provisions that apply to all participating jurisdictions, we should not construct a system that will encourage different outcomes in different states.

Suits against states filed by providers over payment rates have caused the greatest problem to the states. Under the Administration's plan, the Boren Amendment and related provider payment provisions would be repealed, thereby eliminating these causes of action by providers. Thus, under the Administration's plan, state concerns about limiting their exposure to suit in federal court would be resolved largely.

On balance, when we assess the three components required to make any guarantee real—the definitions of eligibility, benefits, and enforcement in the NGA resolution—we continue to have concerns because the federal guarantee of Medicaid coverage and benefits does not appear to be real and enforceable for recipients.

Financing

The second key issue is the financing contained in the NGA resolution. The NGA resolution would replace the current financing system with a combination of a fixed federal payment and a payment adjustment for unexpected increased enrollment. The Governors' financing mechanism has the potential to be creative and a workable formula that constrains growth without providing incentives to drop coverage. Their funding approach, which ensures Medicaid dollars increase with enrollment, represents a constructive addition to the debate. As the Governors have noted, however, these provisions must be fleshed out in much greater detail before anyone can

assess whether the financing actually flows based on changes in enrollment and the economy.

The NGA proposal also includes two changes in the state share of financing Medicaid. The minimum federal contribution to the financing of Medicaid would increase from 50 percent to 60 percent, and states' use of provider tax and donation financing mechanisms would once again be unconstrained.

While these proposals are appealing to many states, they raise significant concerns. Depending on the overall structure of the program and on state decisions about program spending, raising the minimum federal match rate from 50 percent to 60 percent either could result in significant increases in federal spending, or reductions in state contributions to Medicaid—and in total Medicaid funding for health care. For example, an analysis of this provision by the Center on Budget and Policy Priorities indicated that if the seven-year federal funding reduction were $85 billion and state matching requirements were reduced in the same manner as the congressional reconciliation bill, states could reduce state Medicaid funding by as much as $182 billion to $214 billion over seven years. Under this scenario, the total federal and state seven year cut could total from $241 billion to $299 billion, and the funding cut could be between 19 percent and 26 percent in 2002.

Defining and revising the appropriate federal and state contributions and spending levels will always be one of the most difficult issues to settle in any Medicaid reform plan. There is no question that these matters merit careful attention in the long-term. However, given the enormous fiscal implications, the President's plan proposes to gain advice from an intergovernmental advisory commission on the appropriate federal and state funding before the Congress proceeds to change the current distribution.

The NGA plan would also permit unconstrained use of provider tax and donation financing approaches for the "state" share of Medicaid. These are the exact mechanisms that the Congress recently limited—in the case of taxes—or outlawed completely—in the case of donations. During the late 1980s and early 1990s, many states took advantage of these funding approaches, costing the federal government billions of dollars and helping drive annual Medicaid spending growth rates up to well over 20 percent. The Congress wisely enacted limits on these mechanisms that remain appropriate today.

In addition, the NGA proposal treats American Indians and Alaska Natives (AI/ANs) in its category of "special grants" that includes "grants to certain states to cover illegal aliens and to assist Indian Health Service and related facilities in the provision of health care to Native Americans." Native Americans have a unique status in that they have a government to government relationship with the United States that distinguishes them from other special populations. Based upon this legal status, they are entitled to benefits promised under federal treaties and trust responsibilities and to any benefits for which they are otherwise eligible as U.S. citizens. The NGA resolution regarding Indian Health services does not acknowledge this legal relationship, nor does it recognize the fact that American Indians possess dual citizenship. They are citizens of both the state and their tribe. The NGA resolution does not recognize the state government's responsibilities to American Indian citizens. We are concerned by policies which make the federal government the sole provider of health care to American Indians and Alaska Natives and abrogate the right of these citizens to participate in state funded services on the same basis as any other state citizen.

Finally, we all have to examine the NGA proposal and financing structure in the context of the effort by the President and the Congress to achieve a balanced budget in seven years. We do not yet know whether this plan will achieve the scoreable savings that are required under the President's balanced budget plan—or under the congressional proposals. If it does not, it would have to be modified to produce savings. Otherwise, other portions of the budget would have to be revised to bring the budget into balance.

Protections for beneficiaries and taxpayers

The NGA resolution would repeal title XIX and create a new title for the Medicaid program. This has the effect of seriously compromising the framework for quality standards, beneficiary and family financial protections, and program accountability.

The NGA resolution is silent in many areas. In other areas where the resolution is specific, some long-standing protections would be reduced or eliminated. For example, the NGA resolution eliminates the federal role in monitoring nursing home quality assurance. Yet without federal monitoring and enforcement of state and facility compliance, the bipartisan uniform quality standards established by the Omnibus Budget Reconciliation Act of 1987 could be undermined significantly.

The NGA resolution makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care. This is a particularly important area since Medicaid managed care enrollment is increasing so dramatically—about one-third of beneficiaries are now in managed care, a 140 percent increase in enrollment over the past three years. The President's plan recognizes the need for updating managed care quality standards. It repeals some outdated approaches and requires states to establish a quality improvement program that must include developing appropriate standards for Medicaid-contracting health plans and using data analysis to track utilization and managed care outcomes.

Finally, the NGA resolution does not clearly address beneficiary and family financial protections such as spousal impoverishment and family responsibility protections that have been central to the Medicaid program for some time. The NGA resolution also does not address the imposition of co-payments and other cost sharing for Medicaid beneficiaries. Further clarification in all of these areas is needed, because these are central elements of the financial security that Medicaid provides today for beneficiaries and their families.

Conclusion

Let me conclude by focusing on one fundamental structural issue—whether we approach the task of Medicaid reform by making changes in the current title XIX of the Social Security Act, or by repealing that program and replacing it with a new title. We support reform, not repeal, of Title XIX. The potential unintended consequences of repealing and replacing this program are staggering—for states, beneficiaries, providers, and the federal government, especially when you consider that it would reopen thirty years of settled litigation. The Congress can address many of the most pressing concerns about any Medicaid reform plan by amending the current law.

From the beginning of the current Medicaid debate, the President has maintained that Medicaid must be financed through a federal-state partnership that ensures federal funding and provides a real, enforceable guarantee of coverage for a defined package of health and long-term care benefits. The President's plan proposes unprecedented new flexibility for the states in how to operate their programs, pay providers, and use managed care and other delivery arrangements, while retaining and revising key standards related to quality and beneficiary financial protections. The President's proposal would achieve those objectives in a way that would also help contribute to a balanced budget by 2002. We believe that the NGA resolution has made a significant contribution to our mutual efforts to reform the Medicaid program. We look forward to working with the Governors, Members of Congress, consumer groups, health care providers, and other interested parties in the near future on this important issue.

WELFARE REFORM

Now I would like to turn to welfare reform. Let me start by reiterating some points the President made in his State of the Union address. Welfare caseloads have declined by 1.4 million since March of 1994—a decline of 10 percent. A larger percentage of those still on the rolls are engaged in work and related activities. Fewer children live in poverty. Food stamp rolls have gone down. Teen pregnancy rates have gone down. At the same time, child support collections have gone up, as the Administration has improved state collection efforts, the IRS's seizure of income tax refunds, and the ability of the federal government to make federal employees accountable for the support they owe their children.

Over the last three years, we have worked with Governors and elected officials to give 37 states the flexibility to design welfare reform strategies that meet their specific needs. This Administration has encouraged states to find innovative ways to move people from welfare to work and to promote parental responsibility, and these efforts already are making a difference for more than 10 million recipients throughout the country. States, led by Governors of both parties, now are demanding work; time-limiting assistance; requiring teens to stay in school and live at home; and strengthening child support enforcement.

President Clinton also has worked with the Congress to expand dramatically the Earned Income Tax Credit to make work pay over welfare. This program, which President Reagan said was the most pro-family, pro-work initiative undertaken by the United States in the last generation, meant that, in 1994, families with children with incomes under $28,000 paid about $1,300 less in income tax than they would have if the laws hadn't been changed in 1993.

Yet, as the President said in January, we should take advantage of bipartisan consensus on time limits, work requirements, and child support enforcement to enact national welfare reform legislation. The President has consistently called for

bipartisan welfare reform and the Administration applauds the way Republicans and Democrats came together to put forth the NGA recommendations. As you may recall, the President started us down this road when he brought together a bipartisan group of congressional leaders, Governors, and federal and local officials to discuss welfare reform at the Blair House last year.

We all want welfare reform that promotes work, requires responsibility, and protects children. Real welfare reform is first and foremost about work: requiring recipients to make the transition into the work force as quickly as possible and giving them the tools they need to enter and succeed in the labor market. This will require a change in the culture of welfare offices so that every action provides support and encouragement for the transition to work.

The President, as part of his balanced budget plan, has proposed a balanced approach to welfare reform that achieves these goals. It replaces welfare with a new, time-limited, conditional entitlement in return for work and gives states new flexibility to design their own approaches to welfare reform. Within two years, parents must go to work or lose their benefits, and after five years, benefits end. The plan provides vouchers for children whose parents reach the time limit, and protects States in the event of economic downturns or population growth. It also has tough child support enforcement measures and preserves the national commitment to nutrition assistance, foster care, and adoption assistance, preserving states' ability to respond to growing caseloads.

The Administration will continue to judge legislation adopted by the Congress on the basis of whether it promotes work, responsibility, and family, and protects children. And, following the example of the NGA and the Senate last fall, we strongly hope for legislation that will be endorsed by a majority of Democrats and Republicans in both chambers of Congress.

The NGA proposal makes numerous modifications to the conference welfare bill—many of which, if adopted by the Congress, would be improvements. Some of NGA's recommendations fall short and should be improved.

On the positive side, the NGA proposal reflects an understanding of the child care resources states will need in implementing welfare reform. By adding $4 billion for child care above the level in the conference report for H.R. 4, the NGA proposal acknowledges that single parents can only find and keep jobs if their children are cared for safely. The additional investment is essential to ensure that child care resources are available for those required to move from welfare to work and—equally important—to ensure that child care is available for low income working families at-risk of welfare dependency. We are troubled, however, that the NGA proposal fails to include Senate provisions for ensuring safe and healthy child care, and that the increased federal spending does not require a state match.

By adding $1 billion to the H.R. 4 contingency fund and allowing states to draw funds if poverty rises, the NGA proposal properly recognizes that states may experience unexpected changes in population or downturns in their economy. In the event of a national economic downturn, however, even a $2 billion contingency fund might be exhausted quite rapidly. During the last recession, for example, total AFDC benefit payments rose from $17.2 billion in 1989 to $21.9 billion in 1992, a $4.7 billion increase over the base year in one year alone. A provision should be added to the bill allowing states to draw down matching dollars during a national recession even if the $2 billion in the contingency fund has been expended. We also believe the trigger mechanism should be improved to ensure greater responsiveness to the states' need for additional resources.

The NGA proposal also would eliminate the requirement in the Senate bill that states meet their full 1994 level of effort in order to be eligible for the contingency fund. The removal of this requirement would allow a state to draw down additional federal dollars while actually reducing its own contribution to the family assistance program. It is difficult to understand why a state in need of contingency fund dollars to meet the demand for assistance would simultaneously be allowed to cut its own spending on poor families below the 1994 level. We support restoring the contingency fund maintenance of effort provision contained in H.R. 4.

The NGA proposal also properly recognizes the importance of child support enforcement to welfare reform. Last year, the President insisted that welfare reform include the toughest child support enforcement reforms in this country's history. Since then, Republicans and Democrats have worked together in a bipartisan spirit and included all of the major proposals for child support enforcement reform that the President requested: streamlined paternity establishment, new hire reporting, uniform interstate child support laws, computerized statewide collections, and drivers license revocation. We applaud the efforts of the NGA and the members of this Committee for their hard work on the child support enforcement provisions. It has been bipartisanship at its best.

On Food Stamps, the NGA proposal makes two important improvements to the H.R. 4 conference bill. First, it does not impose a funding cap on the Food Stamp program as the conference bill did. A cap on Food Stamp spending would jeopardize the ability of the Food Stamp program to get food to people who need it. Second, the NGA proposal protects families with relatively high shelter costs—mostly families with children—by adopting the Senate's approach to the program's deductions from income.

The NGA proposal also makes substantial improvements to the performance bonus provisions in the conference agreement by establishing a separate funding stream to pay for bonuses—rather than allowing states to reduce their maintenance of effort. It makes modifications to the work requirements to make them more feasible and less costly for states to meet. In particular, the Administration is very supportive of provisions that allow part-time work for mothers with pre-school age children and that reduce the maximum number of hours per week from 35 to 25.

The Governors' proposal also is noteworthy because it limits proposed cuts to the Earned Income Tax Credit. We cannot be serious about welfare reform if we cripple the primary work incentive for low-income parents. Along with child care and health coverage, the EITC is vital to helping people move from welfare to work.

Finally, the Administration is supportive of several provisions that the NGA adopted from the Senate-passed bill—a 20 percent caseload exemption from the time limit for battered women, women with disabilities and others who may need a hardship exemption; a state option to implement a family cap; and requirements that teen mothers live at home and stay in school.

The Federal-State Partnership

While the NGA proposal improves on the conference bill in a number of ways, the Administration has serious concerns about several provisions. While it is critical that states have the flexibility to design programs to meet their specific needs, it is equally essential that the federal government ensure accountability in the use of tax dollars and make certain the safety net for poor children is maintained. The federal-state match system under current law always has been the "glue" that holds this partnership together and was part of the welfare reform plan the Administration proposed as part of its balanced budget plan.

A serious concern about the NGA proposal generally is that the federal-state partnership is severely weakened. As I have already mentioned, the Administration prefers the provision in the Senate bill that requires 80 percent maintenance of effort of the 1994 level, and a requirement for a 100 percent maintenance of effort for access to the contingency fund. We also oppose the NGA provision allowing a state to transfer up to 30 percent of its cash assistance block to other programs such as Title XX, the Social Services Block Grant. Since most states spend considerable state dollars on social services, this transfer effectively permits substitution of federal dollars for state dollars.

The problem is exacerbated in the Governors' proposal by the fact that the additional $4 billion in child care funds requires neither a state match nor even maintenance of the FY 1994 level of state effort on child care.

In total, these provisions imply that states could, by law, reduce their spending substantially under the MOE and transfer provisions while federal spending on AFDC and child care programs would continue. One analysis presented before the House Ways and Means Committee by the Center on Budget and Policy Priorities last week argued that states could hypothetically reduce spending by more that $50 billion over the next seven years if they reduced spending to 75 percent of their current effort and transferred 30 percent of cash block grant funds to other activities. Most states would not reduce spending this dramatically, but there is no reason why states should be allowed to reduce spending while Federal support continues at roughly current levels.

Finally, the NGA proposal needs to provide greater accountability for taxpayer dollars and stronger protections against worker displacement. Provisions should be added that provide for accountability in state plan implementation and require a program specific audit within federal guidelines.

Protections for Children

The NGA proposal also contains several provisions that threaten the safety net for poor children. Federal and state child protection programs provide an essential safety net for the nation's abused, neglected and adopted children, and children in foster care. As we embark upon bold new welfare reform initiatives, it is critical to maintain a strong child protection system for these extremely vulnerable children. Unlike the Senate's bipartisan approach to child protection, the NGA proposal jeopardizes this essential safety net by allowing states to replace with block grants cur-

rent entitlements for adoption, foster care, independent living and family preservation. With disturbingly uneven state performance in this area, it also is troubling that the NGA's proposed redesign of the nation's child protection system fails to include a mechanism to enforce protections vital for the lives and well-being of abused and neglected children. The NGA proposal also would block grant important programs focused on prevention of child abuse and neglect. If the system includes no targeted prevention funding, crisis-driven decision-making may deplete resources for prevention.

Food Stamps and Child Nutrition. On behalf of the Secretary of Agriculture, I'd like to discuss a few issues relating to the nutrition programs. While the NGA agreement does include some improvements to the conference report's provisions on Food Stamps, the NGA proposal did not go as far as it should, and serious concerns remain.

- The NGA proposal continues to provide a state option for a Food Stamp block grant. The nutrition and health of millions of children, working families, and elderly could be jeopardized if many states took advantage of this option, as they might under the terms contained in the proposal. Although the Administration is committed to simplification and increased flexibility in the Food Stamp program, we are strongly opposed to a Food Stamp block grant.
- In addition, the NGA proposal continues the proposed Simplified Program to households which receive both Food Stamps and AFDC. While the Administration supports a Simplified Program and has developed its own proposal, the NGA proposal undermines national standards that work and creates a hidden cost for states.
- The NGA proposal severely time limits Food Stamp receipt for many unemployed adults. Anyone who is not willing to work should be removed from the program. But those who are willing to work should have the opportunity and the support necessary to put them to work. Many who are willing to work could lose their Food Stamps because states are unwilling or unable to provide sufficient work and training opportunities. Without resources to provide work opportunities, states could face the burden of caring for thousands of people who have lost nutrition assistance.
- The NGA proposal retains the conference bill's provision for school nutrition block grant demonstrations. The block grant demonstrations would undermine the program's ability to respond automatically to economic changes and to maintain national nutrition standards.

Guarantees of fair and equitable treatment. The NGA proposal does contain a requirement that states set forth and commit themselves to objective criteria for the delivery of benefits and fair and equitable treatment. This is an improvement over the conference bill, which contained no guarantees that states would commit to objective eligibility and other criteria and promptly and equitably serve those who met them. To ensure that applicants and recipients are not subject to arbitrary treatment--for example, being placed on waiting lists—state plans should be explicit, contain certain elements, and bind the states to their commitments. Among those commitments should be applications, eligibility and sanctions criteria, and procedures and time frames for decisions. Moreover, statewideness and equity across families in each state must be the goal. Applicants and beneficiaries should be told the reasons for decisions on their rates. Mistakes in the administration of the program should be correctable. Once these objectives are met, applicants, recipients and other taxpayers in each state will understand the benefits and concomitant responsibilities under their state plans.

Restrictions On Benefits To Immigrants

The recent NGA proposal does not address the immigrant provisions included in the H.R. 4 welfare reform conference bill. That bill would have banned most legal immigrants, including the disabled, the elderly, and children, from receiving means-tested benefits. It also would have excluded illegal aliens from all child nutrition benefits, creating an unprecedented local administrative burden and ultimately denying benefits to millions of eligible children. This provision alone would require all 45 million students enrolled in participating schools to document their citizenship to participate in the federally-supported school lunch program, placing an enormous administrative burden on local school systems.

The Administration opposes deep and unfair cuts in benefits to legal immigrants. Instead, the Administration strongly supports strengthening and enforcing sponsor responsibility for immigrants, by extending deeming provisions until citizenship. It is particularly important to note that the NGA, in its letter to the welfare conferees dated October 10, 1995, specifically *supported* the deeming approach of the Administration and *opposed* the banning provisions in H.R. 4. We are deeply concerned that

the legal immigrant provisions of H.R. 4 will represent an enormous cost shift to certain states, as well as to federal taxpayers, leaving state and local governments solely responsible for assistance to legal immigrants.

In short, the NGA welfare proposal represents an important bipartisan step forward in enhancing the ability of the states to reform welfare by promoting work, encouraging parental responsibility and protecting children. It needs to be improved in important ways. We look forward to working in a bipartisan way to build on the improvements that have been made and to achieve welfare reform of which we can all be proud.

In conclusion, Mr. Chairman, let me restate the Administration's commitment to enact both a balanced budget and Medicaid and welfare reform legislation. As the President has said, budget cutting shouldn't be wrapped in a cloak of reform. Let's pass needed Medicaid and welfare reforms. Let's cut the deficit. But let's not mix up the two and pretend that one is the other.

I know the President shares my hope that with the leadership of this committee, the same level of bipartisan cooperation will exist again on the critical issues of Medicaid and welfare reform.

Because when we are all long gone and the history books of this period have been written, what will they say about our role in this great debate?

Did we give the American people a government that honors their values and spends their money wisely?

Did we balance the budget and shift responsibility away from Washington without breaking our historic promises of health care to seniors, children, and people with disabilities?

Did we enact real welfare reform—not by punishing innocent children, but by encouraging work and responsibility?

Did we give our citizens the tools they need to be both good parents and good workers?

Did we move forward on common ground with a common vision?

Quite simply, did we do the right thing?

That is the challenge facing this Administration, this Committee, and this Congress. And, that is the challenge we must meet together.

Again, I want to thank this Committee for giving me the opportunity to testify today and I look forward to answering your questions.

RESPONSES TO QUESTIONS FROM SENATOR CAROL MOSELEY-BRAUN

Question. Do you believe the NGA's welfare proposal will create an unfunded mandate in urban cities? (i.e., Will the inability of the labor market to absorb transitioning welfare recipients transfer the burden of caring for former recipients to cities and local communities?) Do you have any data that might help quantify the impact of a time limit on cities?

Answer. In designing welfare reform legislation, we must take great care to avoid creating an undue burden on states and localities. In particular, we must address the potential impact of time limits and work requirements in light of the high rate of public assistance receipt among children in some major cities and the scarcity of job opportunities in some urban areas. One of our concerns about the NGA proposal is that the federal-state partnership in maintaining a safety net for poor children may be severely weakened. The NGA proposal only requires that states meet a 75 percent maintenance of effort standard for spending on cash assistance, work activities and child care. It also allows states to transfer up to 30 percent of the cash assistance block grant to child care, child protection or the Social Services Block Grant, enabling states to further diminish the funds they dedicate to their financial support of low-income families.

In contrast, the welfare proposal submitted as part of the President's 1997 budget plan includes a number of important safeguards that would help states and localities succeed in welfare reform. States would be required to provide vouchers to children in families who lose their cash assistance to ensure that the basic needs of children are provided for. States also would be permitted to exempt from the time limit up to 20 percent of their cash assistance cases for hardship situations. In addition, families denied cash assistance due to the 60-month time limit would be considered eligible for and receiving aid for purposes of determining eligibility for and the amount of benefits under other federal and federally-assisted programs, such as Medicaid and Food Stamps. Families would thus be ensured of remaining eligible for these programs under the Administration's plan.

RESPONSES TO QUESTIONS FROM SENATOR SIMPSON

Question. What are the requirements for states requesting approval of waivers to implement welfare reform demonstrations, including the approval process and approximate approval time?

Answer. As Secretary of Health and Human Services (HHS), I have authority to approve waivers under section 1115. of the Social Security Act, if I determine that the request would further the objectives of the Act and that the proposed demonstration project provides an opportunity to learn with a rigorous evaluation. During FY 1995, we approved requests for waivers to implement welfare reform demonstrations at a rate of one every nine working days. In order to minimize paperwork and the amount of time spent on waivers, we established an expedited 30-day process for certain proposals.

Requirements

Because section 1115 is a research demonstration authority, HHS requires that states use an independent evaluator to rigorously measure the effects of waiver demonstrations. Our experience has been that demonstrations with weaker designs proved inadequate. As a result, we now require almost all approved applications to have an experimental design with a control group that receives AFDC under current law rules and a treatment group that receives the demonstration treatment. In large statewide demonstrations the control group is required to operate only in a relatively small number of offices with several thousand cases assigned to it. The state then can test its reform proposal in most of the state with the vast majority of its AFDC population. Relevant baseline and outcome data is collected on experimental and control cases so that the unbiased impact of the demonstration can be determined.

In addition to the evaluation requirement, states must agree to methods that will ensure that the demonstration will be cost-neutral to the federal government with respect to major open-ended entitlements that are likely to be affected by the demonstration. The AFDC, Emergency Assistance, Food Stamp, and Medicaid programs typically are included. Because cost-neutrality is calculated over the life of the project, the federal government may incur limited additional costs at the beginning of the project when start-up investments are being made, as long as these excess costs are offset as savings accrue. Federal cost-neutrality is required in order to ensure that waiver demonstrations do not increase the Federal deficit.

Approval Process

- Federal involvement in considering waivers often begins before a formal application is submitted, as federal and state staff discuss proposed changes.
- On September 27, 1994, HHS issued policy guidelines requiring states to provide public notice prior to submitting applications to ensure a period of public debate.
- After an application is submitted, a federal team conducts a detailed review of proposed demonstration policies to identify issues and areas that need clarification.
- Copies of applications are sent to organizations with an interest in children and family issues and are made available upon request. Further, each month HHS publishes information about new applications in the Federal Register so that an even wider audience will be alerted. We have established a 30-day period for interested parties to provide comments before a decision to approve or disapprove a project is made. Any comments received are fully considered. Comments often have led to significant improvements to the approved demonstration design.
- As issues are resolved and needed clarifications obtained, we develop draft terms and conditions. This document constitutes a cooperative agreement between the Federal government and the State regarding how the demonstration will be implemented and evaluated, and how cost-neutrality will be determined. In general, federal and state teams engage in detailed discussions before reaching agreement on the terms and conditions. From the federal perspective, in accordance with section 1115, we must ensure that the demonstration will further the objectives of the Social Security Act.
- While working out specific implementation details, states sometimes reconsider certain aspects of their own proposals. As a result, they may amend their request.

Approval time

- The median time from receipt to approval is 153 days, approximately 5 months. During FY 1995, HHS approved requests for waivers to implement welfare reform demonstrations at a rate of one every nine working days.
- On August 16, 1995, HHS published a Federal Register notice to establish an expedited 30-day review process for certain proposals that would implement one or more of five strategies for improving the efficacy of the welfare system in helping recipients become self-sufficient.

Question. The Governors did not address the issue of "family responsibility" with respect to nursing home patients. You may recall that Republicans were severely criticized for including a provision in the balanced budget act that would have allowed States to require adult children with incomes above the state median income to contribute towards the care of their parents' nursing home care. I personally feel that a modest copayment might be appropriate—for families who can afford it—when they have elderly parents whose nursing home bills are generously paid by Medicaid. No one is talking about requiring people to "foot the entire bill" of $30,000 a year for nursing home care. After all, our elected State officials have to answer to the voters—just like Members of Congress do—and they are not going to impose unrealistic requirements on them. Yet, there are a number of "interest groups" who seem to believe that the government should care more about nursing home residents than their own families do. How do you feel about permitting the States to require such copayments?

Answer. The Administration is firmly committed to ensuring that the adult children of sick parents are not forced to pay their parents' medical bills or nursing home expenses. Unfortunately, having sick or ailing parents is a fact of life which everyone must eventually face. But if you find yourself in this difficult situation, you should not be forced to decide between a college education for your children and medical care for your parents. Without the current law protections that prevent people from having to pay for their parents' medical care, this is a very real and frightening decision people may face. The Administration is committed to ensuring that the current law protections remain in place so that people are never forced to make such a decision.

PREPARED STATEMENT OF HON. ALAN K. SIMPSON

I am very pleased to welcome the Governors who come before our committee today. Let me say that I admire your sincere efforts to work together to being about meaningful reforms in Medicaid and welfare. You are the ones who administer these programs—you have firsthand knowledge of how these systems are gimmicked and abused—and your recommendations are surely worthy of our earnest consideration.

When I came to the United States Senate in 1979, Federal expenditures on Medicaid totaled $12 billion. Over the years, this program has grown at such an extraordinary pace that Medicaid will consume almost $100 billion in Federal funds in the current fiscal year if we do nothing to change the system. This spending serves a vitally important purpose—meeting the health care needs of millions of Americans who are "at risk" and most vulnerable in our society—but it poses a serious threat, along with other forms of entitlement spending, to the long-term health and well-being of our Nation.

My service of the President's "Bipartisan Commission on Entitlement and Tax Reform" has given me a unique perspective on the hazards of uncontrolled entitlement spending. Let me briefly review some of that Commission's findings: By the year 2003, entitlements and interest on the debt will account for 72 percent of the Federal budget. By the year 2012, entitlements and interest on the debt will consume all tax revenues collected by the federal government. By the year 2030, spending for Social Security, Medicare, Medicaid and Federal Retirement—the four largest entitlement programs—will consume all tax revenues collected by the Federal Government.

These are sobering projections. They tell us that Medicaid and all other forms of entitlement spending are increasing at an unsustained pace. Our task is to slow the growth of these programs without inflicting pain on those who are truly deserving of assistance.

The challenge of reforming welfare is perhaps even more complex and difficult. Not only must we bring welfare spending under control, but we must also restructure the system—with the help of the States—to create the proper incentives for work and self-sufficiency, and to discourage long-term dependency on welfare.

I commend the Governors for giving us some common sense proposals that we can build upon. When our work here is finished and we have enacted some form of Med-

icaid and welfare reform that the President will sign, I think we will be able to look back and say that it was the Governors whose determined efforts nudged—or actually body punched us—in the right direction.

PREPARED STATEMENT OF HEIDI STIRRUP

Mr. Chairman, members of the Committee, I am Heidi Stirrup, Director of Government Relations for the Christian Coalition. Thank you very much for the opportunity to appear before you today to offer some comments on the proposed plans by the Governors to reform the welfare system.

As a pro-family organization, members of the Christian Coalition are comprised of people of differing faiths who are all dedicated to strengthening families and restoring common sense values. Our members are concerned about the breakup of the family, the size and growth of government and the higher tax burden imposed upon them. They expect government policies to look out for the family—encourage marriage, reduce the crushing tax burden and promote policies which value families. The current debate over welfare reform offers a great opportunity to address some of these concerns and perhaps even accomplish some of these goals.

First, I would like to acknowledge the tremendous effort this committee and in particular, the distinguished Chairman, has undertaken to change the Nation's welfare program. The conference report to H.R. 4, the Personal Responsibility and Work Opportunity Act of 1995, which Congress approved in December, in our view, would have gone a long way toward restoring a much needed sense of personal responsibility to social programs. Regrettably, President Clinton vetoed this compromise legislation on January 9 and returned it to Congress.

In reviewing the President's veto message, it is interesting to note that his objections were primarily over work provisions, child care and budget cuts as well as program changes in foster care, food stamps and school lunches. But what was not cited in his veto message was any objection to funding for abstinence education, a family cap or bonus payments to states that successfully reduce their illegitimacy ratios. It is these provisions aimed at reducing out-of-wedlock births that Congress must retain in any future welfare reform legislation. A welfare system that subsidizes illegitimacy, perpetuates illegitimacy and with it, poverty and dependency.

Regrettably, what the Governors have proposed fails to include what we believe is essential to any welfare reform—policies that encourage marriage and reduce illegitimacy. The Governors' plan instead shifts the focus to work and day care. According to social policy experts at the Heritage Foundation, reducing welfare dependence can be accomplished by at least six different ways: reduce illegitimacy; reduce divorce; increase marriage among women not yet enrolled in welfare and who have children out-of-wedlock; encourage single mothers to take jobs before they enter welfare; increase marriage among welfare mothers; and require welfare mothers to take jobs. The governors' plan concentrates on this last point which is the least effective and least desirable way to reduce welfare dependency. Working mothers leaving fatherless children in the hands of government day care is not an acceptable solution. (Children need daddies, not day care.)

Moreover, a study released last June by the Manpower Demonstration Research Corporation found that 82 percent of the 2300 young mothers participating in workfare demonstration programs were still on welfare 18 months after they entered the program. Forty percent found paid work, but many quit because of job dissatisfaction or other work/family role strain. Over 50 percent became pregnant out-of-wedlock after beginning the program.

Rather than advocating policies intended to reduce out-of-wedlock childbirth, Governors ignore the subject altogether and instead advocate more spending on benefits, day care, job training and other welfare services.

Few will dispute the fact that there is a moral and social decline in America today beginning with the decay of the very basic unit of our society—the family. In fact, it seems there has been a steady decline—even destruction—of the family over the last thirty years. What worked for families in the first 190 years of this great Nation has given way to what arguably has not worked. The basic family unit has been under attack from illegitimacy, promiscuity, adultery, divorce and homosexuality. It is the increasing rate of out-of-wedlock births that is particularly shocking and troubling and which demands some attention. Our federal public policies should encourage marriage, help families stay together and discourage out-of-wedlock births.

Programs that were once judged by the height of their aspirations now must be reconsidered by the depths of their failures and the magnitude of their casualties. The current welfare system is considered by many as a complete failure. Over $5 trillion dollars has been spent over the past thirty years and as a result, America

has a larger poverty element that is more violent, more poorly educated and includes many more single parent households than ever before. It is time to try something different. Given an opportunity to change the welfare system without affirmatively addressing illegitimacy, Congress will be responsible for an incomplete and inadequate effort. Social policy experts identify illegitimacy as the single most important social problem today largely because it contributes to many other social problems such as crime, drugs, poverty, illiteracy, welfare and homelessness.

While some may question whether welfare causes illegitimacy, it is certainly true that welfare cash and assistance provides a perverse economic support system for it. A young girl on welfare can get a cash grant, food stamps, medical care, day care, a transportation allowance, and in many cases a rent allowance. This rapid expansion of welfare benefits make welfare more attractive than entry-level jobs and subsidizes unwed motherhood making husbands quite dispensable. In fact, for many fathers, welfare provides an automatic escape hatch. They do not have to take responsibility for their children—the government will.

Out-of-wedlock births are a strong predictor of poverty. Unwed mothers are not only more likely to rely on government to support their children, but are also more likely to spend years dependent upon welfare. According to a report issued by the Heritage Foundation, one in every three children were born out-of-wedlock last year. The illegitimate birth rate continues to rise about one percentage point every year. Children born out-of-wedlock are seven times more likely to be poor than those born to couples who remain married. Girls raised in single parent homes on welfare are five times more likely to give birth out-of wedlock themselves when compared to girls from intact non-welfare families. Because illegitimacy feeds both poverty and itself, there is no way we can reverse the dual trends of welfare dependency and family breakdown until we address illegitimacy.

One significant reform we support is a "family cap"—a restriction on additional cash payments to welfare recipients having additional children while on welfare. We would not oppose an exception for vouchers to provide for the care and feeding of the child, but believe that the policy of providing additional cash for additional children results in a misguided incentive and sends the wrong message. A national poll recently commissioned by the Family Research Council found that a full 84 percent of the 1000 Americans surveyed said they oppose increasing a welfare recipient's monthly welfare check if she has another child out-of-wedlock. Only 13 percent said such increases were justified.

Defenders of the welfare state argue that young women do not have babies just to get their government check. There are perhaps a variety of reasons, but nonetheless, the financial support is what allows this behavior to continue. Taking away the cash incentive could be the single most immediate step to break the cycle of illegitimacy and dependency. Remember, these federal welfare dollars are taxpayer dollars and while Americans generally feel an obligation to support the unfortunate, there is little support for tax dollars being spent to sustain a child fathered by a young man who disappears and leaves mother and child to be wards of the state.

Some oppose federal requirements such as a family cap on grounds that true federalism should allow states to decide how to run their welfare programs and promise that many will come up with their own innovative solutions. The fact that the Governors' proposal recommends elimination of the family cap and offers no other alternative to reducing illegitimacy provides some insight to the fact that they are reluctant to effectively deal with this crisis.

Another argument against the family cap is the fear that such a restriction in cash assistance may result in mothers resorting to abortion. The marital status of a mother is the single greatest risk factor for an unborn child because statistics show that single mothers are about ten times more likely to abort than married mothers. So reducing out-of-wedlock pregnancies will likely reduce abortions. Reducing illegitimacy is far more effective to protecting the innocent unborn than additional cash benefits for unwed mothers. According to the Family Research Center, "the data demonstrates that subsidizing illegitimacy will actually increase the number of abortions because it increases promiscuity and discourages marriage. To follow the logic that reducing entitlements will somehow increase abortions suggests that we should increase entitlements tenfold to save even more lives. Yet the data shows that states that have more generous welfare benefits also have higher abortion rates."

It is important to reintroduce a moral element into the problem of rising illegitimacy. The rise of the welfare state—with its promise of risk-free, value-free sex—led directly to the sexual revolution and the rise of fatherless families. The welfare system provides rewards to young women for certain behavior: have sex, get pregnant, don't get married and the state will take over for the baby's father and will manage the family. This system has produced skyrocketing illegitimacy rates, gen-

erations of women and children dependent upon the state who don't know the value of work. When the state hands out condoms and birth control pills, it necessarily encourages sexual promiscuity. When the state provides an economic safety net, they do so without encouraging marriage or working to prevent the pregnancy at the outset by advocating abstinence.

There is a need to turn back the amoral tide. Private charities have authority to encourage sexual responsibility by valuing marriage and self control and two-parent families. Private charities and faith-based organizations can do a much better job than government of getting prompt aid to those who need it most and can encourage self sufficiency and do so by using resources more efficiently.

Recommendations to Improve the Governors' Welfare Reform Plan:

- Restore the requirement to prohibit states from using federal funds to give additional cash benefits to welfare recipients who have additional children out-of-wedlock, but allow vouchers for the care, feeding and material needs of the child.
- Change the reward incentive eligibility to include instances where welfare mothers marry and exit welfare in addition to finding work.
- Change the bonus payment scheme for rewarding states that reduce illegitimacy without increasing abortion because as drafted, the targets are too difficult to achieve and likely will result in little or no money being paid for real reduction in illegitimacy.
- Restore a requirement to prohibit states from using federal funds to give cash assistance to teenage girls who have babies out-of-wedlock, but allow vouchers for the care and feeding and material needs of the baby.

Instead of offering a vision to reduce dependency, Governors recommend ways for more federal money to provide more social services to the ever expanding dependency population. If Congress is intent on "changing welfare as we know it," then they must include policies that will help people help themselves—a hand-up, not a hand-out.

PREPARED STATEMENT OF JAMES R. TALLON, JR.

Thank you, Mr. Chairman and members of the Committee, for this opportunity to provide some perspective on the Governors' recent proposal for Medicaid reform and its implications for health and long-term care coverage of the low-income population. I am James R. Tallon, Jr., Chairman of the Kaiser Commission on the Future of Medicaid and President of the United Hospital Fund.

The Kaiser Commission on the Future of Medicaid is a 14-member, bi-partisan national commission established by the Henry J. Kaiser Family Foundation in 1991 to serve as a Medicaid policy institute and forum for analyzing, debating, and evaluating future directions for health care for poor and vulnerable populations. I am pleased to be here today to share the work of the Kaiser Commission and discuss Medicaid's role in financing care for 36 million low-income Americans and the National Governors' Association's proposal to restructure Medicaid.

MEDICAID TODAY

Since its enactment in 1965 as comparion legislation to Medicare, Medicaid has operated as a federal/state partnership to meet the health needs of our nation's most vulnerable populations. Medicaid has evolved from a program providing financing to states for health coverage of their welfare population to a program that now finances health and long-term care services for one in eight Americans and accounts for 13 percent of national health care spending.

Over the last 30 years, Medicaid has helped to close the gaps in care between the poor and non-poor, eased financial burdens, and provided a safety net for the most needy Americans: It has been a major force in shaping health and long-term care services for low-income families and aged and disabled Americans and is now the primary source of health care for 36 million low-income children and pregnant women, persons with disabilities, and low-income elderly people.

In fulfilling its multiple roles, Medicaid is configured and operated somewhat differently in each of the 50 states and the District of Columbia. For 17 million children and more than 7 million adults in low-income families, Medicaid provides fundamental health insurance protection. For nearly 4 million low-income elderly people and more than 5 million low-income people with disabilities, Medicaid provides both health insurance and long-term care coverage. In its long-term care role, Medicaid pays for home- and community-based services and is the dominant source of public financing for nursing home care. In its insurance role, Medicaid is a supple-

mentary insurance program for low-income aged and disabled Medicare beneficiaries, paying Medicare's premiums and cost-sharing requirements and covering additional services, most notably prescription drugs. For low-income disabled adults who do not have Medicare coverage, Medicaid also serves as a basic health insurance program.

Although children account for over half of the 33.5 million Medicaid beneficiaries covered by the program in 1994, they account for only 16 percent of program spending (Figure 1). From the perspective of how Medicaid dollars are spent, Medicaid is predominately a program serving the low-income aged and disabled population. The elderly and disabled constitute 27 percent of beneficiaries, but 59 percent of spending because of their intensive use of acute care services and the costliness of long-term care in institutional settings. The average cost of an elderly beneficiary is eight times the per capita spending for a child on Medicaid (Figure 2).

As a safety net for health and long-term care, Medicaid pays the bulk of the cost of care for the nation's poorest and most disabled individuals. It assists individuals with the most catastrophic of illnesses-children with chronic illnesses that can leave them disabled for a lifetime, adults with mental illness and retardation that require extensive care in the community or in an institutional setting, and the frail elderly and the disabled who also need long-term care. Medicaid's average cost for a pregnant women or child without complex medical needs is often substantially lower than a comparable private health insurance premium, whereas the average cost for a severely retarded individual on Medicaid, a population that is generally not covered by most private insurance, can exceed $50,000 per year.

Because Medicaid provides coverage to those with severe health problems and costly medical needs, including segments of the population generally not covered by most private insurance, it has become a major budgetary commitment for both the federal and state governments. Federal expenditures for Medicaid now account for 6 percent of the federal budget while state expenditures (exclusive of federal payments to the states) for Medicaid account for 13 percent of state spending.

In recent years, Medicaid expenditures escalated rapidly, with total federal and state expenditures more than doubling from $51 billion in 1988 to $138 billion in 1994. Total spending for Medicaid in 1995 was estimated at $156.3 billion and is projected grow to $302.8 billion by 2002. The federal share, roughly 56 percent of total expenditures, is projected to grow from $89.1 billion in 1995 to $172.6 billion in 2002.

Although rates of growth for Medicaid have historically been more moderate than increases in private health care spending, Medicaid costs accelerated rapidly after 1988. Annual rates of increase were in excess of 25 percent between 1990 and 1992. The rapid growth rates during this period were attributable to several factors, including a national recession, growth in the number of people eligible for Medicaid, inflation in health care spending, and states' use of statutory loopholes to leverage additional federal dollars.

Spurred by federal requirements to increase coverage of pregnant women and children, state efforts to cover more low-income uninsured, and court-required expansions in coverage of the disabled, enrollment increased from 22 million in 1988 to 33.5 million in 1994. As shown in Figures 3 and 4, although low-income children accounted for the largest share of the growth in Medicaid enrollment, they played a relatively minor role in the growth in Medicaid spending during the 1990s.

The major factor contributing to the spike in program spending in the early 1990s was that some states used provider taxes and donations and disproportionate share hospital (DSH) payments as alternative financing strategies to increase the base payments that had to be matched by the federal government. As shown in Figure 5, the growth in DSH payments had the most pronounced effect on the growth in Medicaid spending between 1991 and 1992. In that period, over half of the annual increase in Medicaid spending was attributable to increased DSH payments, concentrated in about 15 states. By 1994, DSH payments accounted for 12 percent of total Medicaid spending.

Legislation enacted in 1991 and implemented in 1993 to restrict state use of tax and donation financing strategies and curb the growth in DSH payments has clearly had a constraining effect on Medicaid spending. With the new rules in effect, the program's expenditure growth rate has returned to historical rates, leveling off at 9.2 percent per year from 1992 to 1994. Future projections by the Congressional Budget Office assume an annual growth rate of about 9.9 percent over the next seven years. Future increases are expected to be driven primarily by inflation and enrollment growth due to increases in the number of people in poverty and the expansion of coverage under current law to children under age 18 with incomes below the poverty level.

Sustaining the rate of growth in the program in an era of fiscal constraint at both the federal and state levels is a significant challenge facing the program. The structure and financing of Medicaid has become a major issue in the federal budget debate. The policy dilemma at both the federal and state levels is how to restrain the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program in ensuring access to essential health services for the needy.

In the first session of the 1 04th Congress, legislation was passed that would have replaced the Medicaid program and its entitlement to low-income people with a block grant to the states providing broad discretion over program structure in return for a cap on federal spending. Under the Budget Reconciliation bill, federal spending on the program would have been reduced by $163 billion over the next seven years. President Clinton vetoed that legislation in December 1995 and offered his own approach to Medicaid reform as part of his balanced budget plan The President's plan would retain the Medicaid entitlement with limits on federal spending and more flexibility for the states.

THE NATIONAL GOVERNORS' ASSOCIATION'S MEDICAID PROPOSAL

The proposal to restructure Medicaid adopted by the nation's Governors at the National Governors' Association meeting on February 6, 1996 represents their effort to find common ground in the struggle to restrain Medicaid spending, provide more flexibility to states, and protect coverage for the most vulnerable low-income Americans. In seeking this common ground, the Governors' proposal addresses coverage of the low-income population, states' discretion over setting the level of benefits and arrangements with providers of care, and federal and state roles and responsibilities.

The proposal attempts to balance concerns over maintaining health coverage for low-income Americans with states' desire for greater control over program structure and dollars. The extent to which the plan achieves this balance and what would be gained or lost in the restructuring are critical to understanding the potential impact of the proposal. However, the effects of this plan cannot be easily assessed with only the Governors' six-page outline of their proposal for restructuring the program.

My testimony today will focus on the issues and questions raised by the Governors' outline. When the details of the proposal become available, the Kaiser Commission intends to analyze its impact and effects on a state-by-state basis and we would be pleased to submit our analysis for the record at that time.

THE IMPACT OF THE NGA PROPOSAL ON MEDICAID AS A SAFETY NET

Under current law, Medicaid provides an entitlement to health insurance coverage for 36 million low-income Americans. If they meet specific income and categorical criteria and establish eligibility for coverage, they are provided with a defined set of benefits and can enforce their right to eligibility and benefits in federal or state court. For two-thirds of current beneficiaries, this coverage is required by federal law and the remaining beneficiaries are covered at state option. Although services may be mandatory or optional, these individuals have an entitlement to coverage and services.

The NGA proposal seeks to protect the coverage of certain populations currently entitled to Medicaid, but leaves other groups with an entitlement under current law to be covered at the option of the state. Under the NGA proposal, protected groups include low-income children under age 13 and pregnant women, the elderly who receive SSI cash assistance, and welfare recipients (as they are determined by the states). The disabled are listed as a protected group but, instead of using the national SSI disability standards, the definition of "disability" is left to each state.

No assurances are made for poor children ages 13 to 18, the majority of nursing home residents, the medically needy who qualify for Medicaid coverage on the basis of their large medical bills, and the working poor. Low-income Medicare beneficiaries who rely on Medicaid to pay their Medicare premiums and cost-sharing are covered only for cost-sharing and have no protection for the cost of monthly Medicare premiums. Medicare beneficiaries with incomes between 100 and 120 percent of the poverty level lose their entitlement to Medicaid assistance with Medicare premiums.

Even those with assured eligibility have incomplete coverage under the NGA proposal because the benefits are not specified. States would be required to cover a set of services, but would have "complete flexibility" to determine the amount, duration, and scope of services provided. They would no longer be required to provide benefits at levels sufficient to meet medical necessity. This latitude in determining the scope of benefits would allow states to set absolute limits on the number of hospital days

or the number of physician visits covered, resulting in wide variation across states in what is actually covered for the "guaranteed" Medicaid population. There are no specifications for benefits to individuals covered at state option under the proposal.

In addition, the proposal would apparently eliminate the current requirement that benefits be offered "statewide" and be "comparable" across eligibility groups. This means that states could offer benefits packages that differ by county or geographic region. States could also offer various levels of benefits to individuals with different medical conditions. Finally, by redefining the "T" in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, fewer services would be guaranteed for children.

Under the NGA proposal, individuals would lose their private right of action in federal courts to enforce eligibility and benefits. They would be permitted to bring suit in state court only after going through a state-determined appeals process and state remedies. Providers would be prohibited from initiating suits on behalf of patients. This means that beneficiaries would no longer have a right to seek a remedy for the deprivation of medical care in federal courts if they felt a state was violating federal Medicaid law. Moreover, it means that the due process rights of individuals would be defined in the states and thus could differ across the country.

Taken together, the uncertainty surrounding the eligibility guarantee, broadened flexibility in determining services, and the restriction of the private right of action to the state courts raise many questions that need to be addressed before the impact of this proposal can be assessed:

- What kind of coverage would ultimately be guaranteed to individuals and how would this guarantee be enforced?
- Who would lose guaranteed eligibility?
- How much latitude would states have in determining the definition of the disabled?
- Could states exclude specific groups, such as persons with AIDS, or limit their access to vital drugs and services?
- Would states only be obligated to pay for cost-sharing under Medicare and not Medicare premiums for Qualified Medicare Beneficiaries (QMBs)?
- Would states have to meet benefit requirements related to medical necessity?
- How widely would benefits and coverage vary within and among states?

These are issues that need to be resolved in order to understand the impact of the Governors' proposal on coverage of the low-income population. Previous work done by the Kaiser Commission has documented the wide variations across states in their current coverage of the low-income population and the importance of Medicaid coverage expansions in limiting the growth in America's uninsured population. With this in mind, the potential impact of the NGA proposal on state-level differences in the availability of health insurance coverage is important to consider.

IMPACT OF THE NGA PROPOSAL ON STATE FLEXIBILITY

To contain costs, states are seeking greater flexibility over how they structure the delivery of services and pay providers. Today, most states are aggressively trying to move many of their low-income beneficiaries, especially children and adults in low-income families, from fee-for-service care into managed care plans (Figure 6). This year, 30 percent of Medicaid enrollees nationwide will receive care from Medicaid managed care plans. Many states are planning to expand managed care enrollment to disabled beneficiaries, although there is only limited experience in managed care for this population.

However, many states have wanted to move more swiftly, rely more heavily on Medicaid-specific plans, and require more mandatory enrollment than the federal statute permits. Many have sought waivers of federal law in order to implement their managed care plans, but the process has often been both cumbersome and constraining for states. The Governors' proposal 9 would address these concerns by allowing states to pursue managed care without the need for federal approval.

The NGA proposal would also increase states' ability to set payment rates and conditions of participation for health plans and providers. The Boren Amendment, which currently mandates that state payment rates for hospitals and nursing facilities be reasonable and adequate to meet the costs incurred by "efficiently and economically operated" facilities, would be repealed. Providers would no longer have a right to sue over the adequacy of payment. Also, when a state pays for cost-sharing for care received by Medicare beneficiaries who also qualify for Medicaid, the proposal would allow states to use the generally lower Medicaid payment rate instead of the Medicare payment rate as payment in full.

The proposal appears to be silent on standards for many providers (for example, for intermediate-care facilities for the mentally retarded (ICFs/MR) or home health

agencies). Federal nursing home standards enacted in 1987 to protect the health and safety of nursing home residents would remain in effect, but responsibility for enforcement would be moved from the federal to state governments.

Allowing states greater flexibility in service delivery and payment raises a number of questions:

- Will states continue to provide insurance coverage to Medicaid beneficiaries or will they limit access to a select set of providers?
- Will plans or providers be willing to participate in the program with further declines in payment rates?
- What standards will be used for participation of plans and providers?
- Will payments to plans and providers assure adequate access to care?
- How will increased reliance on managed care and changes in provider payment affect the safety-net providers that have traditionally served this population?
- Will states shift Medicaid dollars from current services to support state-run services, such as inpatient mental health facilities?
- How will the quality of plans and providers that participate be enforced?
- Without federal standards and enforcement, will quality of care in nursing homes and ICFs/MR decline?
- What safeguards will patients have with regard to choice of plans and providers?

Previous research has shown that access to care for low-income populations can be impaired if payment rates are inadequate to guarantee provider participation and if quality standards are weak or poorly enforced. As states move to implement managed care and cost containment programs, attention must be given to safeguarding the quality of care and access to care for poor and vulnerable populations that do not have the financial resources to go "outside the Medicaid system."

IMPACT OF THE NGA PROPOSAL ON FEDERAL AND STATE ROLES

Under current law, Medicaid is a federal/state partnership in which federal funds flow to match state expenditures as enrollment and service costs rise. The federal share of costs is determined by a formula based on state per capita income and the amount of federal funds to any state is determined both by the matching formula and the level of state expenditures. Federal costs increase as state expenditures grow.

The Governors' proposal seeks to define and limit federal and state financial responsibilities for coverage of the poor, but assures increased federal funds to states to accommodate growth in beneficiaries. The proposal would limit federal spending by establishing a limited or maximum allocation of federal funds. Although the details are unspecified, the proposal would establish a base allocation to states, and would allow growth (through a growth factor and an "insurance umbrella") in that allocation to reflect increases in the population served by the program. In addition, special federal funds would be provided to certain states to provide care to native Americans and to illegal aliens. Finally, the proposal would reduce the maximum state requirement from the current 50 percent to 40 percent of total spending under the program. Current restrictions on provider taxes and donations as sources of state matching funds would be eliminated.

The absence of detail in the Governors' proposal leaves considerable uncertainty as to the adequacy of federal or state funding to assure an adequate safety net. If funding from either partner in the program fails to reflect changes or growth in the population in need or increases in the overall cost of health care, people will go without care or providers, especially safety-net providers, will be left to shoulder the burden. At the federal level, the Governors' proposal leaves uncertain what growth rates will apply to federal funds and the circumstances under which the "umbrella funds" will be made available. Both are critical to assuring that states have adequate federal dollars available to serve their populations, as economic and demographic circumstances change. At the state level, the proposal creates uncertainty about state obligations to provide adequate matching funds for the safety net. New opportunities to use provider taxes and donations, as well as reduction in matching rates, create the potential for a substantial withdrawal of state funds.

The proposed restructuring of the federal/state partnership also generates concern about state accountability for the use of federal funds. Under current law, the federal government finances over half of the Medicaid program's costs. Under the Governor's proposal, the federal share would increase from 56 percent of program costs to more than 60 percent. Along with giving states greater flexibility in managing the program, it is essential to assure that states are held accountable for using federal dollars to assure the guaranteed and meaningful coverage that is the program's primary goal.

Further consideration of the NGA proposal therefore requires answers to several critical questions:

- Will sufficient federal dollars be available to reflect changing economic and demographic circumstances in the states?
- Will states sustain financial support for Medicaid in response to lower matching requirements?
- Will the federal and state governments shift burdens to safety-net providers?
- How will states be held accountable for the use of federal dollars?

The financing structure and adequacy of the financing for coverage of the low-income population are fundamental to understanding how this proposal would affect coverage of the low income population and program costs. Recent experience with Medicaid clearly shows that the "financing rules" can result in wide funding disparities across states, as evidenced by the rapid growth in DSH spending and the concentration of this money in 15 states.

THE CHALLENGES FACING MEDICAID

There are no simple solutions to reducing the cost of providing care to the 36 million Americans who now rely on Medicaid or the millions more who fall just beyond its reach. There are only hard choices. The Medicaid program is currently set up as an entitlement for low-income, elderly, and disabled Americans, just as health insurance for workers and Medicare for older people entitles them to benefits. Medicaid is also an entitlement to states for federal matching funds for individuals and services that fall within federal guidelines. Simply put, individuals are currently guaranteed coverage if they meet the eligibility requirements and states are guaranteed fiscal assistance for themselves and their low-income residents.

In addition, the matching funds provided by the federal government through Medicaid enable states to respond to changes in the economy that affect the number of poor and uninsured in each state, to accommodate population growth, and to undertake health and long-term care reform at the state level. Programmatic changes such as the ones before us today will inevitably affect the poor, the old, the disabled, and the children protected by Medicaid's safety net, simply by altering the conditions upon which states and beneficiaries have come to rely.

While the states have argued that with greater flexibility they can run their programs to do more while spending fewer dollars, the details underneath the sweeping term "flexibility" are likely to entail limits on eligibility and benefits, cuts in provider payment, and the imposition of cost-sharing and premiums for the poor. The Kaiser Commission's report, "Cutting Medicaid Spending in Response to Budget Caps," examines the choices available to the states to reduce spending without cutting eligibility and shows how difficult it will be to implement these options.

There is no magic or painless solution-no magic wand of flexibility that can provide medical care and long-term care to one in eight Americans at a dramatically lower cost. Broadened use of managed care will require time to implement and even then will not accomplish big overall savings for Medicaid unless extended to the elderly and disabled populations, both groups with limited managed care experience. Changes in the delivery system can be made to accomplish savings but, in order to be effective and preserve access to needed services, these changes will require time to implement and the development of an adequate infrastructure to deliver care.

Restraining the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program is a daunting task. A dramatic devolution of the federal government's responsibility for Medicaid to the states will not solve the problem of maintaining Medicaid's safety net responsibilities; it will merely shift the hard choices and responsibilities to the state governments that are already struggling with their own fiscal problems. The Governors' proposal demonstrates that the states are looking for fiscal protection, not increased financial responsibility for the Medicaid safety net.

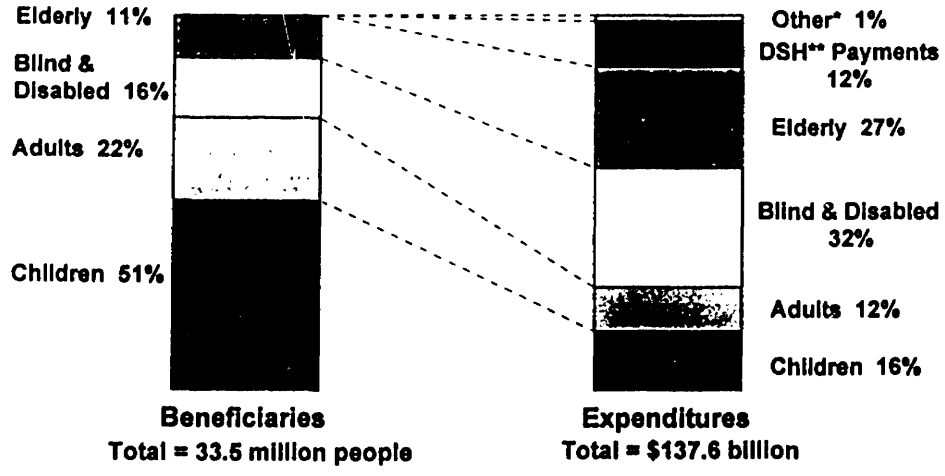
Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health delivery and community-based long-term care services, and stood alone as a primary source of public assistance with nursing home care. Together, the federal government and state governments have much to be proud of in Medicaid's accomplishments. In addressing the crises of today, we should recognize the progress Medicaid has made in providing health and long-term care services to low-income, elderly, and disabled Americans and the importance of this program as a safety net for our most vulnerable citizens.

Thank you.

Attachment.

Figure 1

Medicaid Beneficiaries and Expenditures by Enrollment Group, 1994

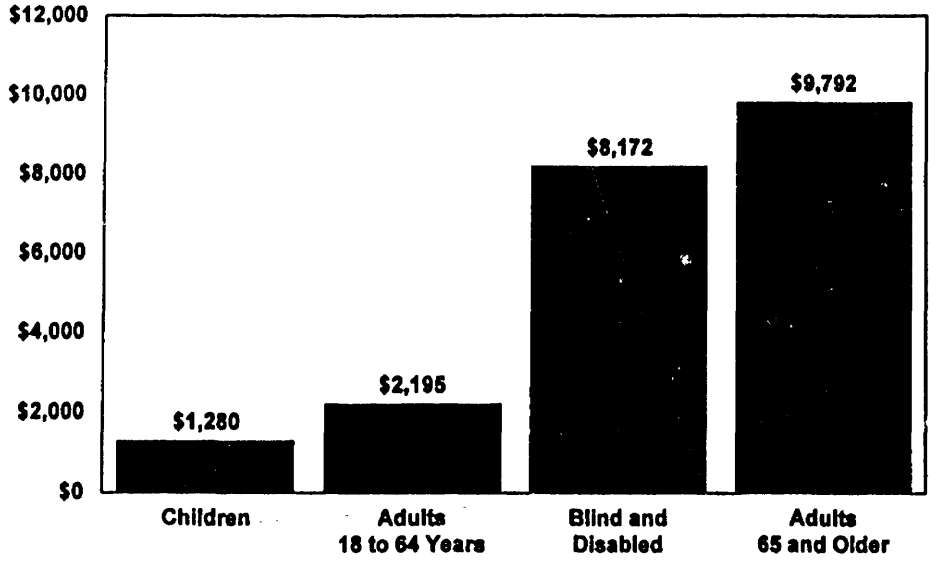


* "Other" includes Arizona, U.S. territories, adjustments and collections. Administrative costs not included.
** Disproportionate share hospital payments.
Source: Urban Institute analysis of HCFA data, November 1995.

The Kaiser Commission on THE FUTURE OF MEDICAID

Figure 2

Medicaid Expenditures Per Beneficiary, 1994



Source: The Urban Institute analysis of HCFA 2082 and HCFA 64 data, 1995.

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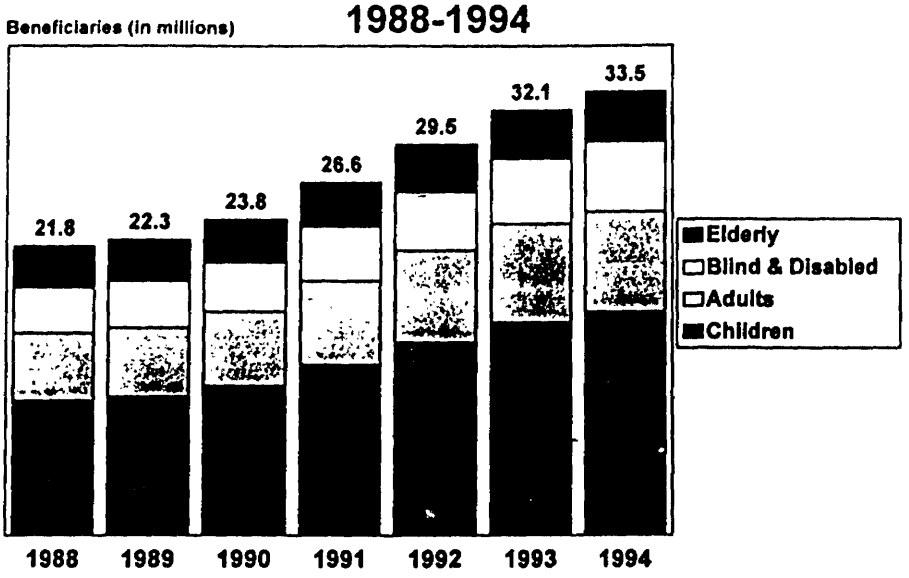
Figure 3

Medicaid Beneficiary Growth by Enrollment Group, 1988-1994



Source. Urban Institute analysis of HCFA data, November 1995.

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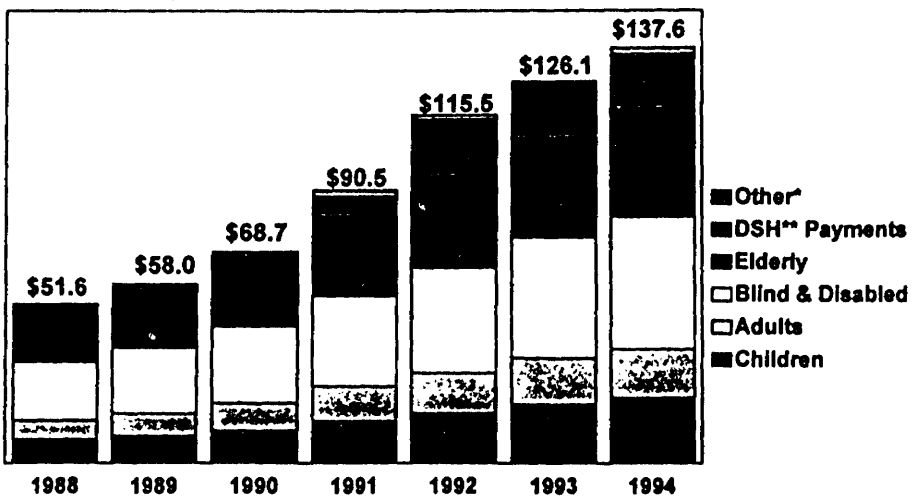
Figure 4

Medicaid Spending by Enrollment Group, 1988-1994



* "Other" includes Arizona, U.S. territories, adjustments and collections. Administrative costs not included.

** Disproportionate Share Hospital payments

SOURCE: Urban Institute analysis of HCFA data, November 1995.

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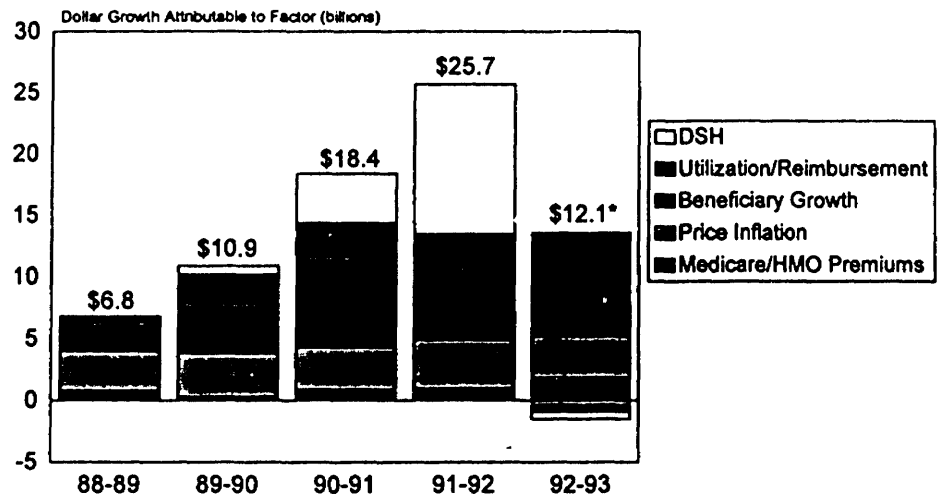
Figure 5

Decomposition of Medicaid Expenditure Growth, by Year



* $12.1 billion indicates net growth, reflecting the decrease in DSH payments and utilization/reimbursement.
Source: The Urban Institute calculations based on HCFA 64 data, 1995.

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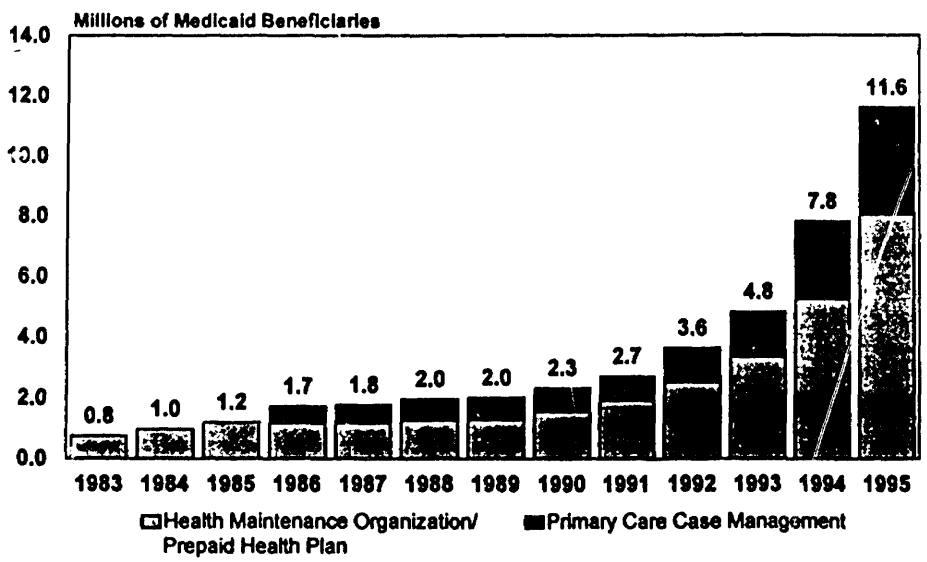
THE FUTURE OF MEDICAID

Figure 6

Growth in Medicaid Managed Care Enrollment, 1983-1995



Source: Health Care Financing Administration, 1996.

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THE FUTURE OF MEDICAID

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

On February 6, 1996, the National Governors' Association (NGA) approved a proposal that would radically restructure Medicaid. NGA's six-page document proposes to eliminate most of the existing federal law regarding Medicaid (it appears to repeal Title XIX of the Social Security Act), leaving unanswered many important questions about what federal Medicaid protections would replace them.

AARP believes it is critical that state and federal lawmakers work closely with program beneficiaries and consumer representatives to address the problems facing Medicaid; namely, high costs, diminishing care, the need for greater flexibility with appropriate safeguards, and the persistence of unmet needs. We commend the Governors for their painstaking bipartisan efforts to develop an outline of a proposal that reflects their views and preferences. However, a significant number of questions and concerns remain, particularly about the impact the proposal would have on the vulnerable, low-income beneficiaries served under Medicaid's essential "safety net." Our primary concerns are expressed in this testimony.

While the NGA proposal appears to provide a minimum federal "guarantee" to some health and long-term care coverage for low-income children, elderly, and disabled, it is very unclear how far this "guarantee" actually extends. In particular, there are a number of critical questions regarding whether and how federal funding would be capped in the aggregate at a reduced rate of growth, how the insurance "umbrella" would work and whether any guarantee is enforceable. It does not appear, for example, that states would receive federal assistance to care for eligible persons if inflation or the cost of services increases at greater than anticipated rates, or if costs increase due to changing levels of disability and case-mix in populations served. In addition, it appears that states would not receive the federal dollars needed to extend Medicaid eligibility to new low-income populations in order to meet growing health and long-term care needs. It is also unclear whether guaranteed coverage would be extended to the vast majority of Medicaid eligible nursing home residents, who are currently entitled to care but are medically needy or have incomes above the 100 percent of SSI level described in the proposal.

Currently, states have flexibility to determine which optional services their Medicaid programs will cover, and states are gaining increased flexibility to use various managed care delivery approaches. AARP supports increased state flexibility with appropriate safeguards. However, the NGA proposal would eliminate important federal rules that safeguard against the provision of inadequate health and long-term care. We are concerned that states would be permitted to severely limit services to less than medically necessary amounts by placing restrictions on the amount, duration, and scope of services rendered. Under the NGA proposal, nursing home residents would no longer have the assurance that once they qualify for Medicaid coverage, it would not be cut off arbitrarily. States might also be able to reduce care based on where an individual lives in the state or based on the individual's particular disability.

We remain concerned about the significantly diminished opportunity individuals would have for redress if coverage is denied improperly under a reformed Medicaid program. Currently, consumers have access to state and federal courts through a private right of action. The NGA proposal would limit federal rights of action, raising additional questions about the nature of the guarantees in the proposal. Specifically, will adequate legal representation and remedies be available to low-income plaintiffs who claim that a state has violated a federal standard? Would state judges, most of whom are either appointed by Governors or elected, be sufficiently independent and insulated from state political concerns to render unbiased opinions?

We are very pleased that the proposal appears to maintain much of the current Medicaid protections for Qualified Medicare Beneficiaries (QMBs) below the poverty level who need help in paying Medicare premiums, deductibles, and coinsurance. However, current Medicare premium protections for beneficiaries between 100 percent and 120 percent of the poverty level appear to be eliminated. Thus, Medicare beneficiaries at these income levels ($7,470—$8,964 for singles and $10,030—$12,036 for couples) would have to pay the full cost of premiums in order to have access to Medicare services. This would create a serious problem under current law and, if Medicare premiums were to increase, would be more problematic.

We are also concerned that the proposal to pay QMBs for services provided at Medicaid, rather than Medicare, rates could jeopardize access and permit states to charge beneficiaries the difference. State attempts to pay the Medicaid rate have been overturned by several courts, who have expressed concerns about diminished access for low-income beneficiaries. For example:

> Deeming dual eligibles and QMBs to be primarily Medicaid rather than Medicare patients prevents health care providers from collecting their reasonable costs or charges. Providers will consequently refrain from treating the most vulnerable of the elderly and disabled, those who are also poor. *New York City Health and Hospitals Corp., Medical Society of the State of New York, et al. v. Perales,* 954 F.2d 854 (2nd Cir. 1992) at 859.

Under current law, by the year 2002, Medicaid would guarantee coverage for children 18 years old and under living below the poverty line. Unfortunately, the NGA proposal would cut off this coverage at age 12. This group should not be singled out to lose the protections they would have under current law.

We are also concerned that, under the NGA proposal, the states would define who is disabled, with no clear criteria for review by the Secretary. Some states could attempt to define disability very narrowly, which could deny coverage for a significant number of needy individuals.

We are pleased that the NGA proposal would maintain federal nursing home quality standards; however, we are concerned because states would be given responsibility for enforcing them. The clear history of lax state enforcement could mean that quality standards would have no teeth and may be ignored. The landmark 1986 Institute of Medicine report, *Improving the Quality of Nursing Home Care* expressed very serious concerns about state enforcement, specifically: "The committee was made aware—at its public meetings, by many letters from individuals, from interviews conducted during its case studies, and by stories that appeared in the press and on television in several states in the course of this study—of the serious, even shocking, inadequacies of enforcement in many states." The report also stated that enforcement "varies widely among the states and within states" and that "inadequate enforcement is a major problem." The report specifically recommended "increasing both federal oversight and federal support of state enforcement activities" and "a stronger federal role in the enforcement system."

We are also concerned that the proposal is silent on a number of essential protections for Medicaid-eligible nursing home residents and their families. In that the NGA proposal appears to repeal Title XIX, this "silence" is particularly troublesome. We urge Congress to retain these current protections:

- protection against spousal impoverishment, and the ability of individuals to seek redress if this protection is not honored;
- protections against placing liens on homes and family farms if spouses or other relatives have been living there for a period of time;
- prohibitions against forcing adult children to pay for their parent's nursing home care;
- prohibitions against providers requiring consumers to supplement Medicaid payments, and the ability of individuals to enforce these prohibitions; and
- protections regarding certain transfers of assets, the repeal of which could create great hardship for residents and their families.

Several provisions in the NGA proposal would reduce states' financial responsibility for Medicaid at the expense of beneficiaries and the federal government. Many states would see their Medicaid match dropped to only 40 percent, significantly reducing total Medicaid spending in these states. The twelve wealthiest states would be permitted to reduce their share of Medicaid costs from 50 percent to 40 percent. Several other states could also continue to receive full federal payments while reducing their own spending, though not as dramatically. According to the Center on Budget and Policy Priorities, total projected state spending could be reduced by over $200 billion over 7 years under this provision. The NGA proposal would also allow states to engage in provider "taxes and donations" schemes that would reduce "real" state funds for Medicaid and potentially siphon them off to other activities. In 1991, in response to reports that some states were misusing federal Medicaid funds and

diverting them to non-Medicaid activities, Congress overwhelming passed legislation to stop inappropriate "taxes and donations" schemes. These proposals that permit reduced state Medicaid spending, coupled with reduced federal spending, would make it virtually impossible to continue a strong health care safety net.

Virtually everyone agrees that there are substantial opportunities to simplify the Medicaid program and make coverage more rational. In many instances, states have wanted to move ahead with innovative approaches. Although we believe that states already have a great deal of flexibility in the Medicaid program, AARP would support even greater flexibility when it would expand coverage, improve services, or contain costs without jeopardizing access or quality. On behalf of our members and their families, AARP will endeavor to continue to play a constructive role in strengthening our nation's health care "safety net" and in striking an appropriate balance between protecting Medicaid beneficiaries and providing the flexibility needed to provide better services.

Attachment.

QUESTIONS ON NGA MEDICAID PROPOSAL

OVERALL APPROACH

NGA's six-page proposal appears to repeal Title XIX of the Social Security Act and eliminate most of the existing federal law regarding Medicaid. Repealing Title XIX would risk losing important statutory federal protections. The following questions explore to what extent Medicaid would continue to serve as a "safety net" for low-income children, disabled, and elderly if new Medicaid legislation were based on the NGA proposal.

ELIGIBILITY

- What is the federal "guarantee" if states, without national standards, can decide on their own to limit services below medically necessary amounts, with only very limited consumer protections to seek redress?
- What criteria would HHS use to determine if the state's definition of "disability" is acceptable and not too restrictive? Eliminating Title XIX would eliminate a 30-year history of state and federal case law protecting individuals with disabilities. Would the NGA proposal supersede the Americans with Disabilities Act and other protections, allowing states to discriminate based on a specific disease or disability?
- Would states be subject to any federal standards in determining whether individuals had incomes and resources low enough to qualify for Medicaid? Could states count items such as personal property, a car, etc., as income in making this determination? Could states count items currently excluded under federal law from the definition of resources?
- The NGA proposal would eliminate Medicaid coverage for children in poverty above the age of 12. How would these children receive coverage? Would currently eligible 11-year olds lose Medicaid coverage when they turn 13?
- Would the coverage guarantee for elderly meeting SSI income and resource standards be different from current law, i.e., does he/she need to actually receive SSI?
- Could "medically needy" individuals access the insurance umbrella? What if states expanded their current medically needy program or created one: How would these eligible persons be treated?
- Would states that want to expand eligibility for optional groups receive additional federal funding? If not, this would mostly hurt states that have a large—and growing—number of uninsured and/or those needing long-term care, but have not already built up their Medicaid program.
- For optional eligibility groups, could states make eligibility dependent on what area of the state the individual lived in?
- Would federal spousal impoverishment protections be eliminated, allowing states to impoverish the spouses of nursing home residents? If spousal impoverishment protections remain, would the current requirement that allows spouses to keep income up to 150% of the poverty level remain the same? How would these protections be enforced?
- Would current federal protections regarding estate recovery and the imposition of liens be eliminated or weakened?
- Would current federal protections which prohibit states from forcing children to pay for their parent's nursing home care be eliminated or weakened?
- Would current federal protections regarding transfers of assets be eliminated or weakened?

- Would current federal protections that require providers to accept Medicaid as payment in full be eliminated or weakened? How would this be enforced?

BENEFITS

- Currently, while most Medicaid beneficiaries receiving long-term care services are in optional eligibility groups, once an individual qualifies for Medicaid coverage, he or she can rest assured that Medicaid will not arbitrarily cut them off during the year. If states have complete flexibility to determine the amount, duration, and scope of benefits under the NGA proposal, could they set limits on services such as a 90-day limit on nursing home stays, reduced nursing home benefits for Medicare beneficiaries only, 5-day limit on hospital stays, etc.? Would there be any federal oversight to protect consumers from potential harm?
- How would long-term care options be "significantly broadened?"
- What is the rationale for allowing a state to provide a different (and possibly lesser) package of benefits (with no minimum requirements) for optional eligibility groups?
- Should nursing home benefits be guaranteed for optional groups when appropriate for the individual?
- Could states limit certain types of benefits to certain parts of the state (i.e., offer a richer package of benefits in urban vs. rural areas)?
- Would states have complete discretion in imposing cost-sharing on beneficiaries, potentially making these benefits unaffordable and inaccessible? Could cost-sharing include a premium requirement?

PRIVATE RIGHT OF ACTION

- Will the time and expense of exhausting all state administrative and judicial remedies preclude most individuals or classes from ever reaching federal court?
- If the only way to go immediately into federal court is to have the HHS Secretary bring suit on behalf of an individual or class, what process will there be for accomplishing this? What standards will the Secretary follow in determining whether or not to sue? How can individuals or groups effectively communicate to the Secretary the need for the Secretary to bring suit in federal court on their behalf?
- Will adequate legal representation and remedies be available to low-income plaintiffs claiming a state has violated federal standards?
- Would state judges, most of whom are either appointed by Governors or elected, be sufficiently independent and insulated from state political concerns to render unbiased opinions? Low-Income Medicare Beneficiaries (QMBs and SLMBs)
- Would the federal guarantee of Medicaid payment of Medicare Part B premiums for near-poor seniors (SLMBs between 100% and 120% of poverty level) be eliminated?
- Would states be allowed to force QMBs and/or dual-eligible Medicare beneficiaries into managed care as a condition of receiving Medicaid coverage?
- If states pay the Medicaid rate (rather than the Medicare rate) to providers on behalf of QMBs and dual-eligibles, would Medicare beneficiaries be responsible for the unpaid amount, either for cost-sharing or the total payment difference?
- Would a mechanism be established for monitoring whether states paying for QMBs' services, at Medicaid rather than Medicare rates, create access problems for beneficiaries? If these payment rates were found to be a barrier to access, what protections would be available to beneficiaries?

FEDERAL FUNDING

- As currently written, the federal funding mechanism is very unclear. This, in turn, makes it impossible to determine how eligibility and services would be affected. How much would the proposal save or cost?
- How would the growth formula work across states? How would the growth formula affect individual states? How would it adjust for changes in case mix,disability level, and age of population? Is there an overall cap, a per-capita cap or both? Since all states can choose their own base funding year, the growth rate is likely to be very restrictive, particularly in later years. How would a cap be enforced?
- What rules would be used to determine if a state has used up its base plus growth funds, and whether there is a "demonstrable need?"
- What federal protections would there be against states using federal Medicaid funds inappropriately? Would states be allowed to use federal Medicaid funds to replace current state spending on Medicaid for state government employees' health insurance or health care for prison inmates?

INSURANCE "UMBRELLA"

- How much money would be allocated to the fund? What happens if the funds are not sufficient to meet clear needs?
- Could a state expand eligibility to an optional group currently not covered by the state, and receive federal matching funds under the insurance umbrella?
- Would the umbrella be triggered if there is an unanticipated change in case mix? An unanticipated increase in inflation? In the cost of services?
- What is the rationale for prohibiting states from accessing "umbrella" funds for children who are Medicaid-eligible at the state's option?
- What are examples of "unanticipated consequences" that would increase the number of Medicaid beneficiaries and trigger use of the insurance "umbrella?" How long would it take to determine if additional "umbrella" payments should be triggered? Would the Secretary make these determinations? Could states appeal an adverse determination? To whom?

QUALITY OF CARE

- Would all current federal nursing home quality standards (excluding enforcement) be retained?
- What role would the federal government have in enforcing nursing home quality standards? What would happen if a state refused to take any action against a nursing home despite a finding of substandard care or an immediate and serious threat to resident health and safety?
- Would all existing managed care protections for consumers be eliminated? Would all federal oversight of Medicaid managed care be eliminated?
- Would the current federal minimum Personal Needs Allowance (PNA) be retained? Would rules regarding what nursing home items and services Medicaid pays for be retained?
- Would federal quality standards for other providers, such as ICF/MRs and home health agencies, be weakened or eliminated?
- Would there be any mechanism available to consumers to ensure that payment rates would be sufficient to provide quality care? Would consumers have any input in making these decisions through hearings or rulemaking?

SERVICE DELIVERY

- Could states force Medicaid beneficiaries to use a single HMO, hospital, physician or nursing home without any choice of provider?
- Would there be a provision to prohibit a state from setting reimbursement rates so low that not enough providers or managed care plans sign up to treat Medicaid beneficiaries?
- Would states have authority to pay providers arbitrarily in rural areas substantially less than providers in urban areas or vice versa?
- Would the current federal prescription drug rebate program in Medicaid that has saved billions of dollars over the past few years be eliminated?
- Would states be permitted to establish restrictive prescription drug formularies?

STATE SHARE

- According to a recent study by the Center for Budget and Policy Priorities, total state Medicaid spending could be reduced by over $200 billion under the provision which would scale back the maximum state share of Medicaid funding from 50% to 40%? Would there be a reduction in eligibility or services in the 12 states most affected by the reduced state match?

PLAN ADMINISTRATION

- Words such as "unburdened," "streamlined," and "commensurate" used in the NGA proposal to describe the new federal oversight role are very vague. What federal oversight provisions will be included in statute to ensure that federal funding is used appropriately and that state Medicaid programs meet federal standards?
- Would the proposal eliminate the "statewideness" requirement that protects against special treatment in one area of the state (e.g., for political reasons) at the expense of another area of the state?
- Would the proposal eliminate the "comparability" requirement that prevents states from covering services for one population, but not others?
- Would the proposal eliminate the requirement that prevents states from discriminating on the basis of diagnosis or condition?

- Will the Secretary continue to be permitted to "disallow" Medicaid dollars (i.e., deny a portion of federal matching payments) to states that are not in compliance with federal standards?

TAXES AND DONATIONS

- Would states be allowed to return to the days of "taxes and donations" schemes that funneled money through hospitals, nursing homes and physicians in order to increase federal funding without the required state match?
- What would CBO score as the federal budget cost of eliminating federal "taxes and donations" restrictions?
- Would states that have already violated the current federal "taxes and donations" restrictions be allowed to keep the federal funds that were illegally obtained?

DISPROPORTIONATE SHARE HOSPITALS (DSH)

- Would all federal restrictions on state use of disproportionate share hospital payments be eliminated?
- Would states that have already violated the current federal DSH restrictions be allowed to keep the federal funds associated with these illegal transactions?

STATEMENT OF THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION

(SUBMITTED BY STANLEY B. PECK, EXECUTIVE DIRECTOR)

The American Dental Hygienists' Association (ADHA) appreciates this opportunity to submit its views with regard to the National Governors' Association (NGA) Medicaid reform plan.

ADHA is the largest national organization representing the professional interests of the approximately 100,000 licensed dental hygienists across the nation. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide primary clinical, therapeutic, and educational services supporting total health through the promotion of optimal oral health.

ADHA is vitally interested in Medicaid reform proposals because both children's and adult oral health benefits are currently provided under the Medicaid program. Children's oral health benefits are required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Adult dental benefits are provided as an optional benefit in 29 states.

As the NGA plan is reviewed by Congress, we urge that the following changes be made:

1. Preserve Children's Oral Health Benefits under EPSDT—Congress should specifically require all medically necessary preventive and primary oral health care services for children who qualify for EPSDT. ADHA urges Congress to ensure that states do not impose arbitrary limits on oral health care services. States could impose such limits because the NGA plan affords states "complete flexibility in amount, duration, and scope of services." This flexibility should *not* be allowed to limit the provision of medically necessary preventive and primary oral health services.

2. Maintain Oral Health Services for Adolescents—The NGA plan would limit oral health care services to low-income children only through age 12. Current Medicaid law envisions a phase-in of all low-income children under age 19 by the year 2002. The proven benefits of preventive oral health care should be extended to *all* low-income children, including adolescents. This is especially important for oral health care services because, unlike most medical conditions, the three most common oral diseases—dental caries (tooth decay), gingivitis and periodontitis (gum and bone disease)—are proven to be preventable with the provision of regular oral health care services. This proven ability translates into huge cost savings. Each $1 spent on preventive oral health care yields $8-$50 in savings.

ADHA urges that the above-noted changes be incorporated in the proposed NGA plan or any other Medicaid reform plan acted upon by Congress. Any reduction in oral health care services currently provided under Medicaid will not only worsen the nation's already inadequate access to oral health care services, but also will retard the nation's ability to achieve prevention of oral disease that is in our grasp. Despite the known benefits of preventive oral health care, the Institute of Medicine estimates that 50% of Americans do not receive regular oral health care. Congress should not facilitate any decrease in access to cost-effective preventive oral health care services.

ADHA also wishes to express its support for the provisions in the NGA plan that facilitate enrollment of Medicaid beneficiaries in managed care organizations. Managed care and dental hygiene are a natural complement to one another because both managed care and dental hygiene emphasize prevention and cost effectiveness.

Please do not hesitate to contact me (312/440-8911) or our Washington Counsel, Karen S. Sealander, of McDermott, Will & Emery (202/778-8024), if you have questions or need further information.

STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL–CIO

The American Federation of State, County and Municipal Employees (AFSCME) submits the following statement for the hearing record on the National Governors Association's (NGA) recommendations to reform the Medicaid and welfare programs.

As a union representing 1.3 million men and women who work in state and local government, nonprofit organizations, and hospitals throughout the country, AFSCME fully supports initiatives to improve the delivery of government services. We applaud increased flexibility to make government programs more responsive to the public. However, increased flexibility in the Medicaid and welfare systems should not undermine their basic objectives, make current recipients of services under these programs worse off, or destroy the federal government's duty to see that federal tax dollars are spent wisely and in accordance with the national objectives.

The NGA plan fails on all three counts. Indeed, it threatens access to health care for the 35 million Americans currently served by Medicaid and the viability of our nation's public guarantee of basic assistance for all children by destroying minimum federal standards in each program. In doing so, it gives the states in general—and the Governors in particular—unprecedented control over vast sums of federal funds with minimum accountability.

While the NGA plan may have advantages for the nation's Governors as they seek to address their own fiscal challenges, AFSCME strongly believes that Medicaid and welfare reform must also take into account the needs of the people served, the interests of the federal taxpayer, and the broader impact on the economy. AFSCME urges the Committee to consider, among other issues: the consequences of cost-shifting to local governments; competing budgetary pressures on state legislatures, which already are starting a "race to the bottom" among neighboring states in funding services for the poor; the aggregate impact on the economy and existing health care system of reducing health care spending by hundreds of billions of dollars; and the extent to which existing federal support for American families will be undermined in the absence of federal safeguards.

MEDICAID

The NGA proposal does not guarantee comprehensive health services to our most vulnerable citizens. It would erode coverage for millions of people in at least four ways: it would not guarantee coverage to certain groups whose coverage is currently mandated; it would allow states to put limits on the scope and duration of benefits; it would encourage states to reduce their own spending on Medicaid by at least $180 billion over the next seven years; and it would not allow the program to adjust sufficiently during a recession to cover additional needy people.

1. Elimination of Coverage for Certain Groups

Poor children over the age of 12, some low-income disabled persons, and some adults with children whose coverage is now required by federal law would lose that guarantee under the Governors' plan. Disabled persons would be especially vulnerable to cutbacks and loss of coverage under the NGA plan, as states would be free to set their own eligibility criteria. Without the federal Social Security standards for disability determination, disability would become politicized, with state legislatures and Governors deciding who are the "deserving disabled." There are currently six million disabled people who depend on Medicaid for their health care.

Not only is the NGA "guarantee" dubious given the loopholes written in the proposal, but the legal enforceability of that guarantee is equally dubious. Neither beneficiaries nor providers could seek redress in federal court to enforce any rights which may appear to be granted under a new federal law to replace the Medicaid program.

2. Benefits Limited

While the NGA proposal talks of a "guarantee," it is effectively an empty guarantee because states would be free to decide which services would be included in their

state Medicaid plans, and could place all kinds of limits on these services. Bare bones benefit packages could become the norm. Different benefits could be available depending on geography, category of eligibility, employment status, or other factors.

3. Incentive for States to Reduce Their Commitment

Like the Medigrant proposal described in the reconciliation bill, the NGA proposal would eliminate the matching commitment by both the federal and state governments to fund the Medicaid program. This matching program rewards states which make a commitment of their own state dollars to support the program, and reduces the likelihood that states will cut their programs during economic downturns when demand is greatest.

By reducing the state matching rates while fixing the federal share, the NGA proposal would allow states to cut almost $200 billion of their own funds over the next seven years *without loss of federal dollars.* Moreover, while both provider taxes and disproportionate share payments are important elements of the Medicaid program, the NGA proposal would allow states to shift their funding from general fund, or general revenue sources, to provider taxes and donation schemes which would allow them to reduce their own match even further with no penalty of lost federal funds.

4. No Real Safeguards for Economic Downturns

While the NGA proposal acknowledges the inevitable situation in which states are unable to cope with rising caseloads during an economic downturn, the "umbrella" mechanism described would not function as effectively or adequately as the current matching rate system does—or as effectively as a per-capita cap with a preserved entitlement would.

WELFARE REFORM

As with Medicaid, the NGA proposal for welfare reform does not guarantee the most basic economic security for poor families. AFSCME strongly opposes the NGA plan because it eliminates federal protections for needy families who comply with program rules and try unsuccessfully to find jobs; destroys accountability mechanisms, particularly in the public administration of welfare programs; eliminates the federal/state matching structure in favor of block grants which allow states to withdraw substantial state funds without losing federal money; and will destroy decent jobs; permit subminimum wages for welfare workers, and depress wages for the low-wage workforce as a whole.

1. Loss of Entitlements

The Governors' plan eliminates the 60-year federal guarantee of a basic level of assistance for poor children even if their parents meet program requirements and play by the rules. Instead, states could set time limits as short as six months or less, establish waiting lists for services, take several months or more to act on an application for services, and decide to centralize services in a few locations as a cost-savings measure. Such actions undoubtedly will lead to increased child poverty, which already afflicts 15.7 million, or one-quarter, of our country's children.

Additionally, like H.R. 4, the NGA plan would not require that states use their block grant to provide cash assistance. Instead, the current cash assistance program could be replaced partially or completely with contracts for services such as transportation assistance, job search, and child care. As a result, families could be left without the financial resources necessary to survive.

AFSCME also opposes the state-option block grants approved by the NGA, including Food Stamps, foster care, adoption assistance, child welfare, and school nutrition (on a demonstration basis). These programs can literally be the difference between life and death for kids in need of child protective services or those threatened with malnutrition. We must ensure that these safety net programs are available for all children, no matter where they live.

2. Loss of System Accountability

Currently, state and county welfare offices provide cash benefits to all eligible families. Federal law requires states to protect program operations from political influence and corruption by having merit-based personnel systems for employees taking welfare applications and paying benefits. The NGA proposal would allow states to dismantle this system without adequately addressing the issue of government accountability if the federal government ceases to set minimum program standards.

The Governors attempted to provide a remedy for this lack of basic safeguards by recommending that state plans include objective criteria for the delivery of benefits and fair and equitable treatment for recipients. However, this proposed remedy is inadequate because it fails to address the issue of equal and universal access to

services, and it is nonenforceable. A fair and equitable treatment requirement, while requiring that similarly situated persons be treated the same, would not mandate assistance to all who qualify. Moreover, states are not required to comply with any provisions in their state plans.

The failure to require that the new program be administered by a public agency, operating under merit-based personnel standards, further erodes the notion of fair and equitable treatment. Public administration, particularly of the most basic eligibility determination function, is an absolute prerequisite for ensuring fair and equitable treatment for program recipients. This is particularly critical when assistance is denied, reduced or terminated. Under the current program, a family can appeal any adverse decision, and has the right to a hearing.

Under the Governors' plan, more than $15 billion federal dollars could be subject to waste and abuse if the integrity of public funds is not protected. Converting the current cash entitlement into a block grant would allow states to contract for a variety of activities without explaining how contractors were selected.

The contracting process diffuses program responsibility, is hard to monitor and invites influence peddling by companies with political connections or money. Awarding private contracts to administer welfare programs could throw us back to a spoils system where jobs are paybacks to political contributors while poor families don't get the financial help they need.

3. Withdrawal of State Funds

The NGA's proposal further weakens maintenance of effort requirements for states. All of the congressional bills and the Governors' proposal would eliminate the state/federal matching structure, replacing it with fixed block grant funding to the states. Under the NGA proposal, states would only have to contribute 75 percent of what they spent on their work, income support and child care programs in 1994. Even if a state decided to spend more than 75 percent for these programs, it would not receive any additional federal funds.

If states choose to contribute the minimum required, the Congressional Budget Office (CBO) projects that state spending for these programs would fall $28 billion, or 30 percent, below that which would be required under current law for the years 1997-2002. Without accusing states of mean-spiritedness, we believe that other pressing budgetary demands on state legislatures will discourage them from funding these programs beyond the minimum required by federal law. The Governors eliminated an important incentive for states to contribute 100 percent of current spending when they deleted the federal matching requirement for states to be eligible to receive contingency funds during economic downturns.

In addition, the NGA proposal allows states to divert up to 30 percent of their federal block grant funds to several other programs including the Social Services Block Grant, the child protection block grant, and the child care and development block grant. This will allow states to reduce their own spending by diverting federal funds for income support and work programs to state-funded social service programs.

4. Unrealistic Work Requirements / Inadequate Anti-Displacement Protections

While we support the NGA's proposed reduction in the number of work hours required of welfare recipients, the work requirements remain unrealistically high. State welfare systems would still be required to dramatically expand work participation by welfare recipients far beyond what is feasible, especially in the absence of any federal job creation strategies.

The NGA resolution does not improve upon the woefully inadequate anti-displacement protections contained in H.R. 4. Although employers would be prohibited from laying off workers and replacing them with welfare recipients, they would be allowed to convert vacant positions into welfare work slots. This will lead to fewer real jobs paying decent wages and benefits. In addition, the Governors' proposal lacks an effective mechanism to enforce the anti-displacement protections.

Neither H.R. 4 nor the NGA proposal retains the requirement that welfare work participants receive at least the minimum wage rate whether they are working off their grants in a "workfare" program or being paid wages as part of a grant diversion program. As a result, employers would be able to replace good jobs with underpaid or unpaid welfare recipients.

Low-wage workers in general would end up paying for welfare reform through lost income. The Economic Policy Institute (EPI) has estimated that if states met these work requirements, the wages of all low-wage workers will fall an average of 12 percent nationwide. The total in lost income to these workers would be approximately $36 billion per year.

CONCLUSION

AFSCME members provide health care and welfare assistance to families and individuals with no place else to turn. The parents who come to a local welfare office have no job and need a way to provide the basic necessities for their children. The children in foster care need a refuge from a dangerous home. The sick in the emergency room have no health insurance and need care for severe illnesses and injuries.

Our members want adequate resources to do their jobs well. They want to provide assistance in a fair and equitable manner. They want to move people from welfare to work and to treat the sick without regard to their insurance status.

The NGA proposal does not advance any of these goals. The clear lesson of the past is that the states separately cannot or will not ensure economic security, fairness and opportunity for all. We strongly urge you not to turn back the clock by turning your back on the most vulnerable in our society.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

I. POLICY PRINCIPLES OF THE AMERICAN PSYCHIATRIC ASSOCIATION GUIDING A RESTRUCTURED MEDICAID PROGRAM

Any Medicaid restructuring should be guided by the following principles to protect the interests of people with mental illness. They assume that States are given much more flexibility in operating their Medicaid program, but that the Federal treasury will continue to finance a major part of the costs.

- Regardless of the ultimate structure of the reformed Medicaid system, coverage of treatment of mental illness should be no more and no less than the coverage of treatment for any other non-psychiatric illness, as consistent with the Senate-passed Medicaid restructuring legislation in 1995 (Conrad Amendment).
- A uniform national standard for defining the "disabled" to specifically include those persons who are disabled due to mental illness-should be retained.
- Managed care must have clearly defined and uniformly applied consumer protection standards to ensure access to quality treatment throughout the full continuum of care. "Flexibility" in managing medical, including mental and behavioral, care must not be interpreted to allow denial of medically appropriate care in order to reduce costs or operate within budget limits.
- People who receive SSI/AFDC benefits must continue to have an entitlement to Medicaid services.
- Medicaid must continue to serve as a safety net for people classified as "medically needy" e.g. people with severe illnesses, including severe mental illness, who are unable to obtain or have exhausted their private insurance coverage. States should be required to include as part of their plan detailed information which specifies their level of effort to provide services to persons with severe mental illness.
- People with illnesses, including severe mental illness, should have access to a broad range of medically necessary services.
- The restructured Medicaid program, and the State optional programs, should ensure patient access to all medically necessary and appropriate care without discrimination on the basis of diagnosis.
- States should be required through a "maintenance of effort" requirement to sustain their current overall level of services and categories of eligibility, at a minimum. Further, States should be required to design systems which enhance collaborative service delivery, limiting duplication and reducing inefficiency.
- The Federal government should continue to exercise a leadership role in establishing (with the States) performance standards and evaluating state rules governing eligibility and ensuring that the amount, duration and scope of services are sufficient to meet the medical needs of patients.
- The Federal government and the States should be required to develop and maintain systems for collecting and distributing comparable data on the costs, utilization and effectiveness of services.
- The Federal government and the States should ensure the confidentiality of personally-identifiable medical information. Information that identifies an individual must not be released without the individual's consent, except in narrowly-defined emergency circumstances.
- Patients, including psychiatric patients and their legal representatives, and physicians, including psychiatrists, should have a voice in decision making affecting the organization and delivery of mental illness treatment services, without restricting their access to the legal system to enforce their medical rights.

II. THE RISKS AND OPPORTUNITIES OF CHANGE

Congress, the Administration, and the Governors are reviewing various options to significantly change Medicaid's structure, operation and cost growth. The changes could pose both risks and opportunities for people with mental illness.

Most recently (February 6, 1996), the National Governors Association (NGA) agreed to a detailed statement of general principles for Medicaid restructuring and reform. As we understand the NGA proposal, it would have a potentially serious impact on provision of Medicaid services to persons with mental illness, particularly with respect to those services which are now deemed "optional" but, as previously identified, are provided widely across the States.

APA welcomes the opportunity to work with the Congress, the Administration, and the Governors on reform and restructuring of the Medicaid program, and offers this document as a guide to legislators and others. Our primary concerns are as follows:

- **Uniform Eligibility for Vulnerable Populations:** The NGA proposal would retain guaranteed coverage for certain specified "at risk" populations.

APA supports the efforts of the Governors to ensure that high risk populations retain uniform eligibility to services. APA also supports retention of guaranteed benefits to the covered populations.

- **Set Aside for Disabled Persons:** The NGA proposal would require the States to set aside funds equal to 90 percent of the percentage of total medical assistance funds paid in fiscal year 1995 for persons with disabilities.

APA supports the proposed set aside, which will help ensure that disabled persons receive the medical care that they require.

- **Insurance Umbrella:** The NGA proposal establishes a safety net insurance umbrella which would protect vulnerable populations in the event that the growth factor in the revised Medicaid formula underestimates actual growth in the covered population.

APA supports the insurance umbrella fund as a safeguard against lack of available coverage due to unanticipated surges in eligible populations.

- **HHS Review:** The NGA proposal would require the Secretary of Health and Human Services to review the adequacy of each State's plan.

APA supports provisions which will help to ensure the adequacy of State plans.

- **Nondiscriminatory Coverage of Treatment of Mental Illness:** The NGA proposal does not address the issue of ensuring parity coverage of treatment of mental illness, regardless of the specific structural reforms adopted by the individual States.

APA urges the Congress to require that—whatever reforms of the Medicaid system are ultimately enacted—coverage of treatment of mental illness be no different than coverage of treatment of any other illness under either the mandatory or optional programs. There should be no "discrimination by diagnosis" in Medicaid restructuring.

- **Disability Definition:** The proposal would leave to the individual States the definition of the term "disabled" for purposes of coverage under the residual mandatory Medicaid program. The lack of a standardized national definition, based on historic stigma, suggests that individuals who currently qualify for Medicaid coverage by virtue of disabling psychiatric illness could be dropped by the States, leaving them without access to necessary public care.

APA respectfully urges that Congress reject the ill-founded discretionary disability definition and instead require the States to cover this population, including all medically necessary treatment for mental illness.

- **Termination of State-Wideness, Comparability, and Freedom-of-Choice: The proposal would appear to vitiate current requirements regarding these important safeguards to appropriate medically necessary patient care.**

APA is concerned that the elimination of these important safeguards may encourage singling out of persons with mental illness for substandard care via behavioral health care carve outs which themselves are not subject to uniform specified patient protection quality of care standards. Further, the reiteration of current policy relative to State "flexibility" in determining the scope, duration, and amount of services raises the prospects for lack of access to all medically necessary treatment for mental illness.

- **Changes in Eligibility for Guaranteed Coverage of Children: The NGA proposal as we understand it would reduce current coverage of especially vulnerable populations, including children, by eliminating the current law gradual phase-in of mandatory coverage of children ages 13 to 18 at 100 percent of poverty.**

APA is concerned that the end result of this proposal may shift at risk low-income children ages 13 to 18 from the prospective "must be covered" category established in current law to the "may be covered" category when they are vulnerable to severe mental illnesses (such as schizophrenia) which often have their onset in early adolescence. Further, the potential fluidity of the State-defined "disabled" population could result in wholesale lack of coverage for those children and young adults most at risk and most in need of medically necessary psychiatric care.

- **Provider Right of Action, Boren Amendment Repeal, Payment Rates: The NGA proposal would repeal the "Boren Amendment" relative to adequacy of provider payment rates; deny providers a specific private right of action, and require that the States "have complete authority to set all health plan and provider reimbursement rates." Further, States would be guaranteed the right to "set their own health plan and provider qualifications standard and be unburdened from any Federal minimum qualification standards . . . "**

APA is deeply concerned that these provisions, together with provisions requiring maximum flexibility of plan design, freedom from Federal standards on state-wideness, comparability, and freedom-of-choice, coupled with current State flexibility on scope and duration, etc., may encourage States to "dive down" to the lowest provider and plan standards and payment rates.

The synergy between these various proposals could effectively curtail access to high quality medically necessary care, particularly for persons with mental illness. These provisions may create incentives to use the lowest cost health plan, which in turn could have incentives to utilize the least qualified (and presumably lowest cost) providers, regardless of whether the providers are appropriately trained and qualified to provide care or are the most appropriate provider of care. By denying providers a right of action, the NGA proposal would curb an important means of safeguarding assurances of medically necessary care. The result could well be a "hollow" State Medicaid health care system which does not adequately address quality of care and appropriateness of treatment.

- **Managed Care Standards:** The NGA proposal on the one had would require that States be given maximum flexibility in design, administration, and coverage under their plans, but does not appear as presented to establish any specific or meaningful patient quality of care standards for managed care plans. Indeed, the States specifically seek maximum flexibility in plan design, provider qualifications, etc.

APA stresses that we do not per se opposed managed care, and recognize that the States are understandably anxious to get their "maximum bang for the buck" in the provision of health care services. APA does, however, adamantly oppose "mangled care," "damaged care," and "managed profiteering" and we are deeply concerned that the absence of any referenced meaningful standards to ensure quality of care, continuity of treatment, access to qualified and preferred providers, etc., will result in a significant deterioration of health care.

- **Nursing Home Standards:** The NGA proposal stipulates that the States "would abide by" current Federal nursing home standards (i.e., OBRA '87 standards), but also stipulates that States must be given "flexibility to determine enforcement strategies" for nursing home standards.

While there is little detail provided in the February 6 statement, APA is deeply concerned that retention of nursing standards without adequate uniform enforcement criteria could result in deterioration of the quality of care in nursing homes, after the arduous struggle to implement in a meaningful way the quality care standards that are the basis for the OBRA '87 law. Further, APA notes that changes proposed by Congress as part of the (vetoed) Balanced Budget Act of 1995 would have specifically impacted provision of services to nursing residents requiring psychiatric care.

For example, that proposal sought to terminate the current law requirement that nursing facilities "attain and maintain" the highest practicable physical, mental, and psychosocial well-being of their residents, and would also have terminated the mandatory use of a uniform minimum data set. The MDS is an important tool in ensuring a detailed assessment of cognition, mood, and behavior. Taken together, implementation of these changes either by statute, or by "flexible" lack of meaningful enforcement, could have a significantly adverse impact on the appropriate assessment, diagnosis, and provision of medically necessary treatment for nursing facility residents suffering from mental illness.

- **"OMB" Payment Rates:** The NGA proposal stipulates that, for purposes of the Qualified Medicare Beneficiaries ("OMB") program, States "may" pay the Medicaid rate in lieu of the Medicare rate.

APA opposes this provision since it would appear to compound a long-standing underlying inequity in the OMB program itself. Under current Medicare law, outpatient psychiatric services—whether provided by a physician psychiatrist, a nonphysician clinical psychologists, or a clinical social worker—is subject to the so-called "psychiatric reduction" which has the effect of increasing the patient copayment to 50%, as opposed to the usual 20% for virtually all other Medicare Part B services.

Under the OMB program, States are required to pay the copayments and deductibles for eligible individuals who are "bought into" the Medicare program by the States. As a result of an extra-statutory policy directive issued in the Bush Administration, States were given the option of refusing to cover that portion of the patient-borne copayment which is deemed as the "psychiatric reduction" thus either reducing the already-low payment to the provider, or putting the provider in the dubious position of attempting to collect the uncovered portion of the copayment from the OMB patient, who by definition is not likely to be able to afford to pay it. We note that in August, 1995, the U.S. District Court for Maryland overturned HHS policy permitting States to refuse to pay the portion of the copayment determined to be the psychiatric reduction under the OMB program (Maryland Psychiatric Society, Inc. v. Shalala, et al. Civil No. 95-894). The case is currently under appeal.

Adding an additional option that States pay for outpatient psychiatric services at the Medicaid rather than Medicare rate will further reduce the already low payment for such services, increasing the risk that patients may have difficulty in accessing appropriate care.

III. CURRENT LAW (AS OF FEBRUARY, 1996) MEDICAID PROGRAM

Medicaid is a joint Federal-State entitlement program that pays for medical services for specified low income persons. Enacted in 1965, Medicaid is administered by the States, subject to Federal guidelines. To participate in Medicaid, States must agree to provide certain mandated services to eligible individuals. In addition, States have the option to offer additional services authorized in the Federal law. For children, States are required to go beyond the services in their State plan to provide all services included in the Medicaid statute necessary to treat or ameliorate any condition identified by a comprehensive screen.

Medicaid represents a major source for financing treatment of mental illness. In 1990, Medicaid expenditures on treatment of mental illness were $8.1 billion, representing 19 percent of the total $42.4 billion estimated public and private spending for mental illness treatment services. In addition to representing a major financing source, Medicaid has also encouraged the expansion of innovative community-based treatment modalities for people with serious mental illness such as psychiatric rehabilitation, case management, personal care services and day treatment/ partial hospitalization services.

- *Mandatory Services:* All States are required to provide:
  - Physician Services (including services of psychiatrists)
  - Inpatient and outpatient services in general hospitals
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children
- *Optional Services:* States may provide (relevant to mental illness treatment):
  - Other diagnostic, screening, preventive and rehabilitative services (used in 33 States to cover psychiatric rehabilitation for adults and children).
  - Clinic services (39 States include mental health clinic services).
  - Prescription drugs, covered in all States (except some States provide only limited coverage of psychotropic drugs).
  - Targeted case management (covered in 39 States).
  - Services of other (non-physician) health professionals (clinical psychologists in 38 States, clinical social workers in 5 States and advance practice psychiatric nurses in 12 States).
  - Personal care services for persons with mental illness (covered in 13 States).
  - Inpatient psychiatric services for children under age 21, including services in residential treatment facilities (covered in 44 States). Inpatient services for adults over age 64 (covered in 45 States).
- *Comprehensive Services for Individuals with Serious Mental Disorders*

During the mid- to late-1980's States engaged in a series of expansions to cover a wide array of community services for adults with serious mental illnesses. In the early 1990's, this was followed by a spurt of activity to more clearly define community services for children.

All types of the community services for adults can be covered under the State optional services; for children, such services are mandated if found necessary by an EPSDT screen, whether or not the service is included in the state plan. Nonetheless, States include descriptions of children's services under the various optional categories in order to more clearly define what those services are. Children's services are therefore included in the following summary.

(A) Rehabilitation

The rehabilitation option covers a range of activities: crisis intervention, evaluations, training in medication management, development and maintenance of necessary community and daily living skills (such as grooming, personal hygiene, cooking, nutrition, money management and training in use of community services), individual, group and family therapy and occupational therapy. For children, this option covers screening and assessment, testing, day treatment, in-home services, crisis programs, collateral services for family members, individual, group and family therapy and services to children in residential placements (group homes or foster care).

(B) Targeted Case Management

For adults, targeted case management assists the individual in securing essential benefits and services to which they are entitled, such as disability income support payments, housing, vocational rehabilitation and health services. Targeted case management for children allows families to receive assistance with all aspects of the child's life to ensure that all specific service needs of the child are being delivered through an organized system of care.

(C) Clinic Services

Clinic services include a broad array of services provided under the direction of a physician, including: diagnosis and evaluation, therapeutic interventions (e.g. psychotherapy, medication management and partial hospitalization), and rehabilitative services. Clinic services must be delivered to an outpatient and providers may not be part of a hospital.

(D) Personal Care Services

A few States use the personal care option to provide in-home personal assistance to individuals disabled by mental illness. Services covered include assistance in activities of daily living (such as grocery shopping or meal preparation) and household services provided incidental to services to meet the individual's health care needs.

(E) Other Services

Other categories which States use to provide a comprehensive array of services are physician services, prescription drugs and inpatient services for children in general hospitals and in specialized residential facilities.

- *Coverage of Acute Care*

For individuals needing short-term acute care services, the mandatory services of physicians and general hospitals are supplemented in many States with services of other professionals and outpatient therapy services in community mental health centers and clinics.

- *Disproportionate Share*

Hospitals with a disproportionate share of Medicaid and non-Medicaid indigent patients may receive a special add-on payment to compensate for these costs. Of a FY 1995 national target of $19.224 billion in DSH payments, roughly $3.0 billion may be allocated to psychiatric hospitals.

STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA), a scientific and professional organization representing over 142,000 psychologists and affiliates, has significant concerns about the restructuring of Medicaid as recommended by the National Governor's Association (NGA) on February 6. The APA believes that the proposal does not address vital issues related to eligibility and benefits coverage and would have a negative impact on the lives of children and adults with mental illness or psychological sequelae related to other disabilities.

SEVERE MENTAL ILLNESSES IN THE US POPULATION

One in five families in the United States is directly affected by mental illness. Estimates of the individuals with severe mental illness count approximately 4 million adults and 2 to 3 million children living in community settings—with families or in a group living situations. The most common mental illness among adults are

schizophrenia, anxiety disorders (phobias, panic disorders, and obsessive-compulsive disorders), and affective disorders (depression, manic depression, and dysthymia). Among children and adolescents, common problems include depression, obsessive-compulsive disorders, phobias, substance abuse disorders (fetal alcohol syndrome), developmental delays, attention deficit hyperactivity disorder, and severe emotional and behavioral problems.

Based on information collected by the National Institute of Mental Health (NIMH) and the Center for Health Statistics,[1] in 1989 there were approximately 3.3 million adults 18 years of age or older in the noninstitutionalized population of the United States who had serious mental illness (SMI) in the past 12 months, a rate of 12.8 per 10,000 persons. In addition to this study of the household population, NIMH estimates that 200,000 homeless persons have serious mental illnesses. A recent Institute of Medicine (IOM) report found that the proportion of homeless population with an acknowledged history of prior psychiatric hospitalization ranged from 11.2 to 26 per cent.[2] Among persons with severe mental illness, 1 to 1.1 million are residents of nursing homes and approximately 50,000 are located in incarceration facilities.

Persons with severe mental illness use a wide range of health services. These services can be characterized as acute, follow-up, and long-term care and rehabilitative services. Services include: evaluation and assessment, inpatient treatment, prescription drugs and therapeutic management, psychiatric rehabilitation, case management, emergency services for crisis intervention and crisis residential services, psychotherapy and counseling, and psychiatric hospitalization and residential services. Not all services are needed for every person, and most people need different services at different times in the course of their illness. The combination of intensive treatment and supportive community care, for example, has been found to prevent deterioration and to promote functioning,[3] and organizational alternatives to hospitalization have resulted in effective outcomes for a range of patient populations.[4]

BACKGROUND ON MEDICAID AND MENTAL HEALTH SERVICES

Medicaid and mental health policy have become intertwined. In 1994, according to estimates by the Center for Mental Health Service in the Department of Health and Human Services, Medicaid mental health expenditures were $23 billion, representing 20% of Medicaid costs. And states report that Medicaid is by far the single largest federal program funding mental health services,[5] estimated to represent half of all mental health spending identified by state mental health agencies.

Medicaid funds are increasingly used by state mental health policy makers to substitute expensive, less efficient institutional services for less expensive community-based services for low-income adults, and children with mental health needs. For example, state-controlled mental health expenditures for inpatient services have decreased 22 per cent from FY 1981 to FY 1993 in constant dollars, while ambulatory services expenditures have increased by 124 per cent . In 1993, Medicaid expenditures for long-term care mental health services were approximately $2.08 billion (excluding SNF/ICF and ICF/MR) and comprisded about 4.7 per cent of the total Medicaid long-term care costs.[6] States varied widely in total dollar amount and proportion of mental health services expenditures per total long-term expenditures.

Of the mandatory Medicaid services, the most important for adults with mental illness are inpatient and outpatient general hospital services and physician services. For children, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requires the full range of both mandatory and optional services. However, the most significant strides in the development of services for the mentally ill occurred during the 1980s and early 1990s with the development of optional health services, such as psychiatric rehabilitation, case management, day treatment of children, and other intensive community programs.

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[1] Center for *Mental Health Statistics and National Institute of Mental Health. Mental Health, United States, 1992.* US Dept of Health and Human Services. Washington, D.C. 1992.

[2] Institute of Medicine. *The Future of Public Health.* Washington, D.C. National Academy Press. 1988.

[3] Stein and Test. The Training in Community Living Model: a decade of experience. *New Directions for Mental Health Services.* 1987;62. San Francisco, CA: Jossey-Bass.

[4] Keisler and Sibulkin. *Mental Hospitalization. Myths and facts about a national crisis.* Newbury Park, CA. Sage. 1987.

[5] Lutterman T., Harris B., et al. Funding Sources and Expenditures of State Mental Health Agencies: Study Results Fiscal Year 1993. National Association of State Mental Health Program Directors Research Institute, Inc, Alexandria, VA. 1995

[6] Kaiser Commission on the Future of Medicaid. Medicaid Expenditures and Beneficiaries. The Henry J. Kaiser Family Foundation. Washington, D.C. 1996.

The use of optional Medicaid services has played an increasingly important role in the effectiveness of treatment for persons with mental illness. The most relevant optional mental health services programs include:

- other diagnostic, screening, preventive and rehabilitative services, used to cover psychiatric rehabilitation for adults and children (39 states);
- clinical services for mental health services (40 states);
- targeted case management for adults with serious and persistent mental illness and/or children with serious mental disturbances (43 states);
- prescription drugs for mental illness (50 states);
- personal care services for persons with mental illness (13 states);
- services for other health professionals, primarily psychologists (40 states) and psychiatric social workers (5 states);
- home health care for mental illness (20 states);
- inpatient hospital services for children under age 22; including services in residential treatment facilities (45 states);
- inpatient psychiatric hospital services for adults over age 64 (41 states); and
- nursing facility services for people over age 64 (41 states).

IMPACT OF THE NATIONAL GOVERNOR'S PROPOSAL

As described above, Medicaid is a critical source of funding for both acute and long-term services for low income persons with disabilities. Low income persons with severe mental illness, traumatic brain injury, mental retardation, and developmental disorders receive vital health services through the Medicaid program. Because of the importance of guaranteed health services and the consumer and quality assurance protections included in Medicaid, the APA has several concerns related to the governor's proposal.

Eligibility—Under current law adults and children with mental or physical disabilities generally become eligible for Medicaid through the Supplemental Security Income (SSI) program and due to their lack of income and resources. Additionally, people with mental illness may be covered under the medically needy option[7] in certain states and many children with serious mental and emotional disturbances are eligible by virtue of being in state custody. It is important to note that only about half the number of individuals identified by state mental health systems as having severe mental illness and unable to support themselves qualify for SSI or SSDI—due to the stringent federal disability (SSI) standards.

NGA Impact—The proposal gives the states the power to define disability for the purpose of Medicaid eligibility, thus severing the link between SSI and Medicaid eligibility. As a result there may be substantial differences in the definition of disabilities between states. Many children, adults, and elderly with Medicaid may be deemed ineligible for coverage. It is quite possible that some states will seek to define disability in a way that excludes certain patient groups—either based on social stigma or perceived health care costs.

Benefits—As mentioned above, the numerous mandatory and optional adult services are essential in the care of persons with severe mental illness; including acute, long-term and rehabilitative services. Children's services are covered by the EPSDT program and assure the necessary diagnostic and treatment services for children with severe emotional and developmental needs.

NGA Impact—The proposal retains much of the current law, including a list of mandatory benefits; however it gives states complete flexibility in determining the amount, scope, and duration of benefits. Additionally, it requires states to use 90% of the percentage of total Medicaid funds paid for both mandatory and optional services to individuals with disabilities to be set aside for services under the new program. However, the plan reduces the amount of required state matching funds and, over time, the amount contributed from the federal level.

The impact of these changes can be felt in two ways: (1) limitation of mandatory services or elimination of optional services based on factors unrelated to the needs of the disability community, and (2) limitations on financial resources available for disability services due to fundamental changes in the financing of the governor's proposal. Financial constraints experienced by the states could lead to significant restrictions on available services and current optional services deemed nonfundable.

Mandatory and optional services provisions could be significantly altered based on the lack of a defined standards for amount, scope, and duration of health services for persons with disabilities. Consequently, decisions related to the amount of services may be subject to factors unrelated to the medical needs of the individual, such

[7] Under the medically needy option, states may cover individuals who do not meet the basic income and resources tests for Medicaid, but who have significant medical costs.

as balancing an annual budget, increasing resources to other public/private programs, or a cutting taxes. In some cases, costly optional mental health services (e.g., inpatient psychiatric services, home health care) may be discontinued from Medicaid coverage due to financial constraints experienced by states. For children, the proposal undermines a 1989 federal law that guarantees medically necessary services by removing requirements to treatment after diagnosis for children assisted by Medicaid—the Early and Periodic Diagnostic Screening and Treatment Services (EPSDT). Although children with severe emotional and behavioral problems will continue to have access to professional assessments and diagnosis, they will no longer be guaranteed access to appropriate medical treatment once a problem has been identified.

States will have diminished financial incentive for providing optional adult services. This disincentive is primarily the result of changes in the funding structure for out years. Although states are required to maintain a 90% set aside for the payment of the new disability program, the total amount of funds available to the states in the long-term may be drastically reduced due to the cuts on a federal level and reductions in state matching funds. Studies have shown that the formula used to finance the governor's proposal may result in only requiring states to spend 38-43% less in 2002 than they would spend under current law.[8] In this case, a strong disincentive is created to limit access to certain optional services, rehabilitative or home and community-based services, due to the resource constraints. The proposal also restores state authority to turn provider "taxes" into state matching funds. A strong maintenance of effort is required by states that would not permit states to divert funds from the program.

Given the lack of specific information on the definition of medically necessary services, the determination of amount, scope and duration of services may be based on a specific type of insurance coverage (e.g., the least expensive HMO health plan negotiated by the state) rather than on the medical needs of the individual. The short-term cost savings achieved with these types of health plans may be less cost-effective in the long-term for children and adults with disabilities as compared to the current system. Furthermore, APA supports language that would encourage states to ensure that their medical plans do not include arbitrary and discriminatory limits on mental health care that are not applied to other conditions.

Finally, the NGA proposal allows for states to negotiate contracts for benefits coverage with health plans based on a forecasted Medicaid budget allotment. As a consequence, any financial disturbances in the state budget may result in adjustments (i.e., limitations or removal) made to benefits on a year-to-year basis. This potential disruption and limitation of services may be inconsequential for children and adults requiring only basic primary care services; however, this level of coverage may be insufficient for children and adults with chronic or severe mental and physical impairments (i.e., cerebral palsy, severe developmental disorders, severe mental illness) that require long-term, coordinated access to specialty provider and services.

Types of Health Plans—The proposal would allow states to use "all available health care delivery systems . . . without any permission from the federal government." States could mandate managed care enrollment for all children and adults with serious, complex medical conditions, without federal oversight necessary to ensure access to, and use of, medically necessary health services and professionals.

NGA Impact—Previous studies on the use of managed care plans for persons with psychological disorders have demonstrated the lack of effective diagnostic and treatment procedures received by persons with HMO coverage as compared to those in traditional indemnity plans.[9] Additionally, based on the experience of HCFA 1115 waiver applications, states have provided health coverage based on the types of services rather than on the needs of the individual. As a result, mental health services are commonly contracted as additional services outside of the primary HMO health plan. This dual system disrupts the link between the mental and physical health care of the individual and limits the ability of states to assure quality mental health services. Regulations established by the Federal government require adequate resources and compliance with specific medical practice standards to be monitored by states in the assurance of available quality health for persons on Medicaid. The termination of these quality assurance protections may significantly diminish

[8] Kogan R., Mann C. ,Governor's Proposal Could Weaken Medicaid Dramatically. Center for Budget and Policy Priorities. Washington, D.C. February 1996.

[9] Safran DG, Tarlov AR, Rogers WH. Primary Care Performance in Fee-for-Service and Prepaid Health Care Systems: results of the Medical Outcome Study. JAMA 1994;271(10):1579-1586.

any regulatory measures used to hold health plans compliant with current medical practices.

Protection of Medicaid Recipient Rights—Under the NGA proposal, individuals will no longer be able to bring class actions against states in federal court, and private rights of action for heath providers or health plans would be prohibited.

NGA Impact—Clearly, this proposal severely limits any rights to specific health services through restrictions placed on the patient and the provider and, more importantly, through the removal of private right of action on a federal level. By eliminating the right to appeal in federal court, the NGA plan will make it harder to enforce federal standards. Furthermore, the constitutionality of this item is uncertain.

The American Psychological Association strongly urges Congress to consider the impact of this proposal on the millions of Americans with mental illnesses and other mental conditions who rely on Medicaid for essential health and long term care services. The APA supports efforts—as stated in the NGA report—"toward achieving a stream-lined and state-flexible health care system that guarantees health care to our most needy citizens." However, if the consequence of the NGA proposal is to repeal the individual entitlement to Medicaid for our nation's most vulnerable citizens and diminish medically necessary services for children and adults with disabilities and their families, we must oppose it.

STATEMENT OF THE CHILD WELFARE LEAGUE OF AMERICA, INC.

(SUBMITTED BY DAVID S. LIEDERMAN, EXECUTIVE DIRECTOR)

The Child Welfare League of America, a membership organization of 850 child-serving agencies nationwide, strongly opposes the sweeping welfare and health policy changes proposed by the National Governors' Association. The Governors' recommendations would abandon millions of destitute children and families, place many more children at risk of abuse and neglect, and repeal critical health coverage for children with physical and mental disabilities.

The Governors' proposal might be good news for Governors, but it's bad news for children and families, especially those in deepest need. I urge the Congress to reject this flawed plan and pass welfare and health reform that keeps children healthy and safe and helps families become self-sufficient.

At a time when we need to strengthen our responsiveness to abused and neglected children, the Governors would put many more children at risk of abuse and neglect. They propose to end the 35-year-old guarantee of adoption and foster care assistance and critical services to prevent child abuse and to assist children who have been harmed. The Governors' proposal would undermine the guarantee of foster care and adoption assistance for abused and neglected children.

The Governors would give states the option of accepting a fixed amount of federal funds for foster care, adoption, and independent living services and using these funds (which are now committed to guaranteeing care for children when they cannot live safely at home) for any of a range of child protection activities. Regardless of whether states take this option, virtually all other federal child protection programs, including those aimed specifically at child abuse prevention and family support, would be repealed and replaced with a child protection block grant. Not a single federal initiative focused specifically on the prevention of child abuse and neglect would be maintained.

The Governors propose to end another critical federal guarantee—the 60-year-old guarantee of income assistance to poor families. Families would have no assurance of a job, training, or even cash help. Children would no longer be certain of even minimal aid for their survival. States would be forced to cease providing cash assistance to families, no matter what might happen to the children, after five cumulative years of assistance.

The welfare proposal approved by the Governors would increase federal resources available for income support, work and child care, compared with the congressional conference agreement, but states could withdraw, or divert to other uses, very substantial state resources from these programs—$58 billion between 1997 and 2002—without losing any federal money. States could transfer up to 30 percent of these block grant funds to a wide range of other programs, and they could cut their FY 94 or FY 95 spending levels by 25 percent without being penalized by loss of federal dollars. If all states chose to cut their spending levels by 25 percent, $28 billion less would be spent on destitute families—potentially resulting in one million children being denied assistance.

In the recession of the early 1990s, federal contributions to states for AFDC increased by almost $6 billion. Under the Governors' proposal, when the next recession hits, states would have trouble adjusting a tight budget to meet the sudden increase in families requiring assistance. Yet the proposed contingency fund would provide only $2 billion, only one-third of the amount needed in the recent recession.

The Governors would make deep cuts in food stamp benefits for children and eliminate basic health and safety requirements for child care. They would provide $4 billion more for federal child care funding. However, states would not need to provide any additional state funding to qualify for the funds (only the overall requirement to maintain 75 percent of their 1994 spending on income support, work, and child care). Many states would likely spend less state money on child care than they would have without the addition of these federal funds.

The Governors' Medicaid proposal would severely restrict coverage to poor children, including elimination of the automatic guarantee to health care coverage for children receiving foster care or adoption assistance. It would eliminate guaranteed eligibility for children receiving IV-E foster care and adoption, eliminates guaranteed health coverage for poor children over age 13 and eliminates the current EPSDT guarantee that Medicaid-eligible children will receive coverage for all medically necessary health care.

Even more important, the Governors' proposal could devastate the chances of thousands of special needs children to be permanently placed in an adoptive home. Caring for children with physical and mental disabilities is costly and hard. Children with these problems are disproportionately found in the foster care system because biologic families do not have the support or resources necessary for their care. Because of private insurance restrictions on pre-existing conditions, thousands of otherwise interested families would be unable to adopt these special needs children without Medicaid coverage.

Even more families will be at risk if they do not have Medicaid coverage for needed physical and mental health services. Without the promise of continued Medicaid eligibility, many families willing to take on the challenge of a special needs foster or adoptive child would be financially precluded from doing so.

The Governors' proposal is dangerous and short-sighted. Should these proposals prevail, the safety net would be in tatters. Regardless of the best intentions, many states respond poorly now and, under a block grant, the federal government would no longer ensure that each child in need is protected. A recent CWLA report, *Child Abuse and Neglect: A Look at the States,* found enormous unevenness in how states respond to abused children and other young people in need.

In reviewing this proposal, we urge you to consider its very serious implications for the children and families we serve and for our agencies' ability to serve them.

STATEMENT OF THE COUNCIL OF WOMEN'S AND INFANTS' SPECIALTY HOSPITALS (CWISH)

(SUBMITTED BY JAMES WHITING, EXECUTIVE VICE PRESIDENT, THE WOMEN'S HOSPITAL OF GREENSBORO)

The Council of Women's and Infants' Specialty Hospitals (CWISH) represents nine of the United States' largest hospitals dedicated to the delivery of high risk obstetrical and neonatal care to mothers and their infants. CWISH appreciates this opportunity to share its reaction to the Medicaid reform plan recently endorsed by the National Governors' Association (NGA). Medicaid reform is of enormous interest to CWISH because Medicaid payments constitute approximately 20% to 45% of the care provided at CWISH hospitals.

Because the major decline in infant mortality over the past 25 years is largely attributable to better access to the subspecialty services provided at hospitals such as ours, access to these services must be preserved in any final Medicaid agreement. Indeed, the Finance Committee expressly recognized the importance of access to specialty perinatal care in its fiscal year 1996 reconciliation recommendations (attached in pertinent part).

We are pleased that the NGA plan would require states to provide Medicaid benefits, including prenatal care, to pregnant women and young children with family incomes up to 133% of federal poverty.

As the NGA plan—or any Medicaid reform plan—is memorialized into legislative language, we urge that the following issues be addressed:

1. *Include High Risk Obstetrical and Neonatal Services in the Definition of Covered Hospital Services*—In drafting the requirement that inpatient and outpatient hospital services be guaranteed, a clause should be added that expressly

includes high risk obstetrical and neonatal services under covered hospital services.

2. *No Arbitrary Coverage Limits on Medically Necessary Guaranteed Services*—Consistent with the plan's requirement that certain benefits be assured, states' "complete flexibility in amount, duration, and scope of services" should not be drafted to allow, for example, discharge of Medicaid-covered patients unless medically appropriate. Thus, the legislation should expressly provide that once a Medicaid patient qualifies for one of the guaranteed benefits (i.e., inpatient and outpatient hospital services), all medically necessary care will be provided.

3. *Continuous Eligibility*—Coverage for women who are Medicaid eligible when they become pregnant and coverage for their newborn infants should be required to be continuous from the beginning of prenatal care through the first year of life. This would foreclose, for instance, administrative delays in Medicaid coverage of newborn babies born to Medicaid-eligible mothers.

4. *Flexibility in Service Delivery*—Health care delivery systems that participate in a state's Medicaid program should be required to have a sufficient number of providers of specialty services, *specifically including perinatal specialty* care, to ensure that such care is available and accessible. In addition, health care delivery systems should also be required to provide states with assurances that payments to providers are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

5. *Disproportionate Share Hospitals (DSH)*—States should be required to have a Medicaid DSH program and to target DSH payments to those providers that serve a disproportionate share of low income individuals, specifically including subspecialty perinatal hospitals.

As the details of the NGA plan are formalized, we look to the members of the Finance Committee to ensure that the above-noted issues are addressed so CWISH hospitals will be able to continue providing quality high risk obstetrical and neonatal services to pregnant women and infants in their communities, regardless of economic need.

Please call CWISH Washington Counsel Sally Rosenberg (202/778-8056) and Karen Sealander (202/778-8024) of McDermott, Will & Emery with questions or for additional information.

Thank you for this opportunity to submit our views.

Robert Rector
Senior Policy Analyst
Welfare & Family Issues

The Heritage Foundation

WELFARE REFORM AND THE DEATH OF MARRIAGE

By Robert Rector

Congress is considering adopting a welfare reform plan recently put forward by the nation's governors. Unfortunately, the governors' plan blithely ignores America's No. 1 social problem: the catastrophic rise of illegitimacy.

Nearly a third of American children born last year were born out of wedlock. The illegitimate birthrate is now rising one percentage point every year. In the black community the out-of-wedlock birthrate is now 69 percent. This figure astounds even Sen. Daniel Patrick Moynihan, D-N.Y., who first issued his prophetic warnings about the erosion of marriage among blacks in the early 1960s. Moynihan's warning was dismissed at the time, but the breakup of the black family and the accompanying social calamities have far outstripped his worst nightmares.

Ominously, the illegitimate birthrate among whites is now edging toward 25 percent, almost exactly equaling the black rate when Moynihan first raised his alarm. The white family is now teetering on the same precipice, heading rapidly toward the same lethal decomposition that devastated black communities in the late 1960s and 1970s.

Family collapse is the root cause of other social problems: poverty, crime, drug abuse, and school failure. Children born out of wedlock are seven times more likely to be poor than are those born to couples who stay married. Girls raised in single-parent homes on welfare are five times more likely to give birth out of wedlock when compared to girls from intact non-welfare families. And a boy from a single-parent home in the inner city is twice as likely to engage in crime when compared to a similar boy who is poor, but living with a father and a mother.

The nation's governors have responded to this grim reality by ignoring it. In unveiling their welfare reform plan they have declared that there are three "key elements" to real welfare reform: 1) providing more government-funded day-care; 2) increasing child support payments from absent fathers; and 3) imposing time limits and work requirements (with lots of loopholes) on welfare recipients. The rise in illegitimacy and collapse of marriage do not merit even a token comment, let alone aggressive policies, from the governors.

Thus, over the last year, the welfare debate has undergone a radical metamorphosis from a focus on combating illegitimacy to a focus on providing public support services to an ever-expanding population of single mothers. Eschewing the issue of illegitimacy

entirely, the governors' plan instead appears as preparation for a future in which marriage plays a sharply diminished role, and the government is heavily involved in meeting the needs of an burgeoning population of single-parent families. The triumph of the left on this aspect of the debate has been complete: Fighting illegitimacy is "out" and funding government day-care is "in."

Some would argue that federal action on illegitimacy is unneeded: If left alone, the governors will, on their own, tackle the problem. But the governors' silence speaks volumes. Few, if any, governors have made reducing illegitimacy a central theme of reform; most are reluctant even to mention the topic. But by refusing to acknowledge or mention the collapse of marriage and the rise of illegitimacy in their plan, the governors are implicitly condoning and (through paralysis) ultimately promoting the skyrocketing rise in illegitimacy. They are clearly embarked on a path that will lead, in the near future, to half of all children being born out-of-wedlock and raised in government day-care centers. This is not reform. It is a national disaster.

The governors' plan, borrowing heavily from the "reform" schemes of President Clinton and other liberal proposals, dovetails with the interests of America's huge welfare bureaucracy -- an industry that thrives on social decay. While the plan will trim the growth rate of welfare spending slightly in the near term, by failing to deal with ballooning rates of illegitimacy it sets the stage for an explosive rise in unavoidable welfare and social-service spending in the future.

Nor are the governors alone. Under its recently passed legislation, Congress is committed to spending nearly a half trillion dollars over seven years to subsidize and support illegitimacy and single parenthood through multiple welfare benefits, day-care, job training and other services. Under the congressional plan, government will spend $1,000 to subsidize single parenthood and illegitimacy for each dollar spent to reduce illegitimacy.

The governors' welfare reform plan would distort priorities even further. When the dust settles on welfare reform, even token efforts to fight illegitimacy will have fallen by the wayside.

This is a tragedy. Marriage in America is dying. The governors have prepared not a rescue plan but a coffin. Many in Congress now seem resigned to assuming roles as undertakers. The simple fact is that "welfare reform" is nonsense as long as the illegitimate birth rate continues to rise. The silence of the governors on the issue is deafening. The welfare debate has become like a tea party on the Titanic in which the participants politely refrain from mentioning that the deck is tilting 40 degrees.

Vision and leadership are sorely needed -- and are sorely lacking.

* * *

Note: Robert Rector is senior policy analyst for welfare and family issues at The Heritage Foundation, a Washington-based public policy research institute.

STATEMENT OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

(SUBMITTED BY LARRY S. GAGE, PRESIDENT)

I am Larry Gage, President of the National Association of Public Hospitals and Health Systems (NAPH). NAPH members include over 100 metropolitan area safety net hospitals and health systems. Collectively, these institutions comprise the essential infrastructure of many of America's urban health systems. They provide almost 90% of their services to Medicare, Medicaid, and low income uninsured patients. They also provide many preventive, primary, and costly tertiary care services to their entire communities, not just the poor and elderly. These services include round-the-clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters.

The National Governors' Association (NGA) recently offered a proposal to reform the Medicaid program, which we understand might serve as the basis for legislation offered by the Finance Committee. NAPH clearly supports genuine reform of the Medicaid program. But NAPH's initial review of the NGA proposal summary indicates that the Governors' proposal appears to be designed primarily to reduce state spending on medical assistance, not to responsibly reform the Medicaid program to better care for the nation's vulnerable populations. We are deeply concerned about the impact the proposal would have on Medicaid recipients and other low income populations, and on the ability of safety net providers to care for their patients and communities.

NAPH shares the Governors' goal of guaranteeing health care to our nation's vulnerable populations. But that guarantee must be a meaningful one, a federal guarantee ensuring that low income and uninsured patients receive a specified level of benefits. It must be supported by adequate state and federal financial resources for the safety net providers which care for these populations, and by an effective enforcement mechanism for achieving state accountability. Anything less will damage the safety net health system in many urban and metropolitan areas, and will deny access to care for truly needy citizens. In recognition of these fundamental principles, I offer the following observations and recommendations on the Governors' Medicaid proposal:

Repeal of the Medicaid Disproportionate Share Hospital Program. Of foremost concern to the viability of safety net health providers, the Governors' proposal would include the funding associated with current disproportionate share hospital (DSH) spending in each state's federal allocation, and would repeal any requirement that any or all of these funds be paid to those hospitals that serve a disproportionate number of low income patients. While the proposal would appear to require that these funds be spent on care for low income populations, there is no methodology specified by which this would be accomplished—a provision that is basically meaningless in that it is no different than the purpose of the overall program. Moreover, when coupled with the proposed repeal of the current provider tax and intergovernmental transfer (IGT) provisions, this recommendation simply opens the door to the same state abuses of the DSH program that the provider tax and IGT provisions were enacted to curb, while locking in the current level of federal spending *even in the states which have abused the DSH program.* These well-publicized abuses stand as a good example of what happens when states are given tremendous flexibility to use federal funds but are provided with inadequate oversight on how they spend those funds.

Rather than writing the states a blank check, NAPH urges the Congress instead to support a more fiscally responsible DSH proposal that targets DSH funds directly on hospitals serving the highest proportion of low income and uninsured patients. DSH funding is essential to those urban public hospitals and health systems that provide a substantial volume of uncompensated services to the poor. These are the hospitals for which DSH funds were primarily intended when Congress created the program. This proposal recognizes that some savings could be generated from reduced DSH spending, because not all DSH funds are currently used by states for their intended purpose. As in proposals currently under consideration, such savings should be phased in over time (e.g., DSH funding should be reduced only after the first two years of the seven-year cycle proposed for the budget agreement), with the remaining DSH funds targeted on those hospitals serving a high volume of low income and uninsured patients. This is the approach of the conservative House Democratic "Coalition" proposal, and one being given bipartisan Senate consideration as well. They would reduce federal DSH spending but maintain a federal DSH funding

pool that would be proportionally allocated among hospitals with a low income utilization rate of greater than 25%.

Dangerous Erosion of State Matching Requirements. Several provisions in the Governors' proposal would work in tandem to permit a dangerous erosion of states' responsibilities to finance care for their most vulnerable populations. As the New York Times stated in its assessment of the proposal, these features of the Governors' plan are designed to give the Governors "plenty of room to reduce state Medicaid funds." NAPH strongly urges the Congress to refocus the debate on finding more efficient ways to deliver health care to vulnerable populations, not on simply reducing state spending.

For example, the Governors' proposal would set the minimum federal matching percentage for all states at 60%. Many states would therefore have their state matching percentages reduced, with the result that the state would have to spend fewer state dollars on medical assistance to draw down its federal allocation than if the current federal matching percentage remained in effect. For all states, once a state has drawn down its entire federal allocation, there would be no incentive for a state to expend additional state dollars on medical assistance because there would be no additional matching federal funding. The likely effect will be a dramatic reduction in state medical assistance funding in addition to, and at the same time as, the anticipated reduction in federal Medicaid funding. The New York Times estimates that states would save over $200 billion under this proposal over the next seven years—or over twice the anticipated federal savings.

Repeal of Provider and Local Government Protections. The Governors' proposal would also repeal the provider-specific tax and intergovernmental transfer restrictions in current law. There would therefore be nothing prohibiting states from shifting their match requirements on to health care providers or local governments—or from expanding provider tax and IGT programs to finance their entire Medicaid program. NAPH supports retaining these protections in current law.

Retreat from the Current Federal Entitlement. The Governors' proposal would guarantee some as-yet undefined level of benefits to some (but not all) currently eligible population groups, but would repeal the current individual entitlement to a defined level of benefits (including all current federal requirements as to the amount, duration, and scope of benefits). This retreat from the current level of coverage for low income populations comes at a time when recent data from the Employee Benefits Research Institute reveal that the number of uninsured Americans has increased to 39.7 million. Such a retreat will exacerbate an already tremendous burden of uncompensated care on hospitals and other providers who treat large numbers of low income patients, including the 64 NAPH member hospitals which provided over $4 billion in bad debt and charity care in 1993. Eliminating the individual entitlement without guaranteeing coverage to populations for a defined amount, scope, and duration of benefits will dangerously undermine an already fragile health care safety net.

Repeal of Provider Payment Standards. The Governors' proposal would repeal the Boren Amendment and other statutory provisions governing the rates at which providers are reimbursed and would give states complete discretion to set provider payment rates at any level they choose. NAPH believes that the provisions in current law governing provider payment must be retained. Without these protections, there is no assurance that safety net providers will be adequately reimbursed for the care they provide to vulnerable populations.

In addition, the Governors' proposal would eliminate the federal private right of action in current law for both beneficiaries and providers. Beneficiaries would have a limited ability to seek to enforce the Medicaid laws in state court, but providers would have no private right of action in state court or federal court. NAPH believes that any Medicaid reform legislation must retain a private cause of action for both beneficiaries and providers. This important enforcement mechanism allows individual beneficiaries and the providers which care for them to enforce the Medicaid laws, and has been an effective way for safety net providers to achieve state accountability on behalf of the patients they serve.

Governors Counting Cash Before Reform Is Passed

Budgets Based on Medicaid, Welfare Proposals

By Judith Havemann
Washington Post Staff Writer

Every passing day makes it less likely that Congress will enact GOP Medicaid and welfare reforms that would save the states billions of dollars, but many governors are acting as if they already had the cash in the bank.

Washington's possible failure to act on the proposals would send states such as New York scrambling to make up huge shortfalls later this year.

"It's got to happen in the next month," said Wisconsin Gov. Tommy G. Thompson (R), referring to enactment of the big budget items. "If it doesn't, I don't know what some states are going to do."

New York Gov. George E. Pataki (R), whose Medicaid program is the nation's largest, has introduced a budget that taps into a $1.3 billion Medicaid gold mine opened up by an arcane formula change in the distribution of federal funds that was approved by Congress last year.

That change was vetoed by President Clinton in early December.

Pataki is not alone. Michigan Gov. John Engler (R) has penciled in $320 million in anticipated Medicaid savings to finance a 5 percent increase in funds for Michigan's state universities.

But Congress hasn't passed legislation that would allow Michigan to implement Engler's plan without going through the cumbersome process of obtaining a waiver of today's Medicaid rules.

California is assuming it will have enough authority in a welfare block grant to cut benefits 4.5 percent, and make further cuts after six months and again after 12 months of welfare dependence, according to the Center for Law and Social Policy, a liberal group. The cuts would save about $299 million in the upcoming fiscal year.

Clinton vetoed such a plan, not once, but twice.

In an attempt to force Congress to act, the nation's governors unanimously proposed their own blueprint three weeks ago to break the Medicaid and welfare stalemate.

Congressional leaders are considering whether to attach the National Governors' Association proposals to next month's must-pass legislation to increase the government's borrowing authority.

But Republican congressional aides give the plan only a slim chance of success in this election year, when months will be devoted to campaigning. The governors' proposals have attracted fierce opposition from interest groups representing the poor. Also, many members of Congress in hearings last week raised questions about the cost, workability, philosophy and possible side effects of the gubernatorial plan.

In a crowd of high-stakes bettors, no governor has gambled more on congressional action than New York's Pataki, now in his second year as governor of the state with a Medicaid program so vast it has been labeled the "Medicaid Industrial Complex" by James Fossett, a professor at the State University of New York at Albany.

Medicaid is a $155 billion-a-year joint federal-state health insurance program for the poor. It provides some standard benefits such as hospital coverage for everybody who qualifies but offers states the opportunity to add optional benefits such as prescription drugs if they are willing to put up their share of the cost. New York's $21 billion-a-year Medicaid program offers just about everything.

Furthermore, the state, like many others, has used the program as a form of revenue-sharing, according to Fossett. "In a lot of cases we've really pushed very hard ... to push programs that used to be funded 100 percent by state dollars onto Medicaid. A big slug of Medicaid money goes for special [education]."

New York, with 7 percent of the nation's population, consumes 15.7 percent of all Medicaid money. Its nursing home rates are the highest in the nation, although its nursing home patients are among the sickest. More Medicaid funds are spent on mental health and home care in New York than in any other state, by far.

In his budget, Pataki took advantage of a little-noticed change in the formula for distributing Medicaid funds to the states that was added to a massive deficit reduction plan in a late-night Senate Finance Committee markup on Sept. 29 by New York Sens. Daniel Patrick Moynihan (D) and Alfonse M. D'Amato (R). Both senators are members of the powerful Finance Committee, through which all Medicaid legislation must move.

The amendment changed the Medicaid formula to benefit 21 of the nation's wealthier states that are currently required to fork over more of their own money than others to get federal matching funds.

Right now, the formula says that these wealthier states must put up as much as 50 cents of state money for every 50 cents from Washington. Poorer states can put up as little as 20 cents to get 80 cents from the federal government. Moynihan and D'Amato's amendment reduced the share any state would have to contribute to 40 percent—slashing by one-fifth the amount New York needed to invest to get the same amount of federal dollars.

When Clinton vetoed the balanced budget plan Dec. 6, he also killed the formula change, but Pataki, only nine days away from unveiling his budget, included it anyway and continues to count on its passage.

"From the start this was a very reasonable assumption to make and we expect action to happen," said Peter Murphy, a spokesman for the New York state budget office. The formula change "has broad bipartisan support and is not one of the things that the president has ever objected to."

Lack of action "is a premature concern at this point," he said.

Many advocates for the poor say the budget proposals of Pataki and others confirm their worst fears. They condemn efforts to give governors new flexibility to run the nation's social welfare programs because they fear it will be used to cut benefits to the poor.

The advocates say New York has provided Exhibit A, even before the law has been enacted. The state is proposing to use its flexibility to reduce the amount of money it spends on Medicaid—cutting payments to hospitals and nursing homes, and moving more people into managed care—while offering voters tax cuts in the same budget.

"Given the opportunity, states tend to cut back on low-income programs and use the freed-up money for tax cuts and education and economic development while weakening the safety net," said Iris Lav, associate director for the Center on Budget and Policy Priorities, a liberal Washington think tank.

The fate of the Pataki Medicaid plan in the state legislature is uncertain, but in California, the Democratic-controlled state Assembly has already taken aim at the welfare plan of Gov. Pete Wilson (R).

According to the Center for Law and Social Policy, the California Assembly Budget Committee's review of the welfare proposal is entitled "California Begins the Race to the Bottom."