1 EXECUTIVE COMMITTEE MEETING

2 TUESDAY, SEPTEMBER 26, 1995

3 U.S. Senate

4 Committee on Finance

5 Washington, DC.

6 The meeting was convened, pursuant to notice, at

7 9:15 a.m., in room SH-216, Hart Senate Office Building,

8 Hon. William V. Roth, Jr., Chairman of the Committee,

9 presiding.

10 Also present: Senators Dole, Chafee, Grassley,

11 Hatch, Simpson, Pressler, D'Amato, Murkowski, Nickles,

12 Moynihan, Baucus, Bradley, Pryor, Rockefeller, Breaux,

13 Conrad, Graham, and Moseley-Braun.

14 Also present: Lindy L. Paull, Staff Director and

15 Chief Counsel; Joseph H. Gale, Minority Staff Director

16 and Chief Counsel; Julia James, Chief Health Analyst; Roy

17 Ramthun, Health Analyst; Susan Nestor, Health Analyst;

18 Brig Gulya, Tax Counsel; Kathy Tobin, Welfare and Income

19 Security Analyst; Joe Zummo, Professional Staff member;

20 Ken Kies, Chief of Staff, Joint Committee on Taxation;

21 Leslie B. Samuels, Assistant Secretary for Tax Policy,

22 U.S. Treasury; and Dr. Alexander Vachon.

23

24

25

1 Senator Moynihan. I wonder if I might ask the
2 Committee to attend to a very happy occasion. We
3 replicate what took place in private on Friday, when we
4 met in closed session so that the proposals before us
5 today could be passed out and be readily available for
6 the weekend.
7 So I have the high honor and distinct privilege of
8 passing the gavel--informally, in the sense that it is
9 not mine to pass--to our new Chairman and our old
10 colleague. He and I have served 19 years together on
11 this Committee.
12 The 36th Chairman of the Senate Committee on Finance
13 has lineage that goes back to the beginning of the
14 Republic, from the great members of the Senate who have
15 served. For reasons I cannot understand, the only one
16 who comes to mind right now is John C. Calhoun. There
17 was Henry Clay. There were quite a number of fellows,
18 not all of whom will be as well known to history as
19 Senator Roth will be when he balances the budget of the
20 United States Government in 7 years flat.
21 With that, I have the great honor to turn it over to
22 my good friend and long-time companion.
23 Mr. Chairman? [Applause.]
24
25

1 OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S.
2 SENATOR FROM DELAWARE, CHAIRMAN OF THE COMMITTEE
3
4
5 The Chairman. Well, thank you very much, Pat
6 Moynihan. I do succeed a number of distinguished
7 chairmen, among the best being yourself. And it will be
8 a great challenge to me to live up to the standard that
9 has been established by past chairmen.
10 You and I remember so well Russell Long. There is
11 only one Russell Long. Bob Dole has certainly served
12 with great distinction as Chairman of this Committee.
13 Our good friend, Lloyd Bentsen, of course rose to even
14 greater stars when he became Secretary of Treasury.
15 Senator Moynihan. A parallel star, sir.
16 The Chairman. A parallel star. I stand corrected,
17 Senator Moynihan.
18 So it is with a great deal of humility, but pride,
19 that I accept this gavel from you.
20 You know this is certainly an historic moment. This
21 is a Committee with a distinguished past. And we are
22 about to embark upon a major review and reform of Federal
23 entitlement programs, programs that have grown so fast in
24 three decades that they now threaten the economic
25 security of our nation and the future of our families and

1 children.

2 I am honored, as I said, by the opportunity to serve
3 as Chairman of this Committee. And, Pat, I look forward
4 to working in a bipartisan manner, to focus on the needs
5 of America's future.

6 I know there will be times when it will be difficult
7 to work in a bipartisan spirit because of the nature of
8 the issue. But I do believe that the great strength of
9 this Committee in the past, with the several chairmen
10 that you and I have mentioned, has been to work for the
11 good of America in a bipartisan manner.

12 Let me begin by saying that I am optimistic about
13 our future. I believe that, with the right kind of
14 policies, our children can have a better life than lived
15 by their parents. And I believe that, with the right
16 kind of policies, our homes and communities, our schools,
17 and economic opportunities can indeed be strengthened.
18 Our families can be made more secure, our Government more
19 efficient, more effective, and much more responsive to
20 the real needs of America.

21 But as certain as I am about being optimistic, I
22 also believe that we cannot secure such a future with
23 blueprints prepared for the past. This is what we must
24 keep in mind as we look to accomplish historical reform,
25 to preserve, to strengthen the Medicare program, to give

1 States much needed flexibility, slow the growth of
2 Medicaid, and to better focus the EITC on the working
3 poor with children.
4 Our emphasis is on restoring and strengthening these
5 programs, about returning them to health, so they in turn
6 can meet the needs of succeeding generations.
7 We can save these programs, and work towards a
8 balanced budget, by allowing Medicare to grow at a rate
9 $270 billion less over the next 7 years than it is now
10 scheduled to grow. We can do it by allowing Medicaid to
11 grow at a rate $182 billion less than its current
12 schedule.
13 These are not cuts. We are simply controlling
14 growth. We can work towards a balanced budget by
15 focusing the earned income tax credit on the working poor
16 with children, by moving that entitlement back towards
17 its original intent of providing a buffer against the
18 sting of Federal taxation on low-income earners.
19 By reforming these three programs, along with
20 welfare, we can find $530 billion over the next 7 years,
21 $530 billion that will move us towards a balanced budget.
22 This is what America wants. This is what our economy
23 needs. But, equally important, this is what each of
24 these programs needs.
25 Without reforming Medicare, the program will be

1 bankrupt--bankrupt in the next 7 years. Without
2 reforming Medicaid, it will continue its economy-
3 threatening growth of some 10 percent a year. And,
4 without reforming the EITC, it will remain the fastest
5 growing entitlement, spinning away from its original
6 purpose.
7 The key to our Medicare reform is choice, giving our
8 senior citizens the freedom to choose the programs that
9 best meet their needs. Yes, they will be able to remain
10 in the current fee-for-service program, if that is what
11 they want. On the other hand, they will have the freedom
12 to move to other programs. They will be free to select a
13 plan that better fits their needs, whether it is managed
14 care, HMO, or some other plan, such as MediSave.
15 Choice will result in competition and savings. In
16 fact, choice could work so well that our current
17 projections, projections that keep Medicare solvent
18 through 2007, could be understated.
19 Strengthening this program is critically important.
20 Medicare is important to beneficiaries, as well as
21 providers. To strengthen the program, beneficiaries will
22 continue to pay 31.5 percent of the premium for Part B.
23 In 1997, we will phase out the taxpayer subsidy of the
24 affluent for Part B. We will also increase the
25 deductibles from $100 to $150, and then increase it $10

1 every year thereafter.

2 Savings will be made on the part of Medicare
3 providers, predominately through reductions in growth
4 rates and capital payments. Despite these restraints,
5 providers will continue to enjoy annual growth rates of
6 between 4 and 8 percent over the next 7 years.

7 I think the best way to understand our Medicare
8 proposal is to look at this chart entitled "Medicare
9 Solvency Projections." The chart makes the issue
10 tangible and demonstrates why our efforts to reform the
11 system are so important. The top, or red line charts the
12 rapid spending growth under the current program. The
13 lowest, or green line shows current revenue.

14 As we all know, the HI trust fund begins depletion
15 in October of 1996. From that point on, outlays will
16 continue to exceed revenues. If left unchanged,
17 according to the Medicare trustees, the trust plan will
18 be bankrupt as of February 6, 2002.

19 The blue line charts spending under the program we
20 are proposing. And the gray line shows our revenue,
21 which includes the extension of the State and local HI
22 tax and interest.

23 Now under our program, reforms will extend the
24 solvency of Medicare for another 5 years. But note, even
25 with our significant reform, the trust fund would still

1 be spending more than it takes in through the year 2007.
2 These reforms will give Congress the time it needs
3 to prepare for the anticipated influx of the baby
4 boomers, and this is what we are after in Medicare.
5 Concerning our plan to slow the growth of Medicaid,
6 many Governors have told us that, if there are no
7 entitlements, and States have more control over Medicaid,
8 they can successfully implement our budget plan, a plan
9 that provides States with total flexibility as to
10 benefits and payments to providers.
11 It is important to note, however, that we require
12 States to continue to spend at least 85 percent of what
13 they have been spending on the neediest--impoverished
14 pregnant women, children, disabled and elderly.
15 Towards restoring the original intent of EITC, we
16 need to eliminate waste, fraud and abuse in this program.
17 It is has run throughout the years roughly 30 to 40
18 percent. We need to better focus the program on the
19 working poor, and provide a credit that is fair. The tax
20 credit has grown from 14 to 36 percent in 5 years, and is
21 scheduled to grow even faster.
22 We would eliminate the scheduled increase to 40
23 percent next year. We would limit the program to
24 taxpayers with children, and base eligibility on income
25 status, with all forms of income being taken into consideration.

1 Notwithstanding these changes, Federal spending on the
2 EITC will continue to increase.
3 Well, I think these are common sense reforms,
4 reforms that must be made. Towards meeting these
5 objectives, I look forward to working with all the
6 Members of this Committee, and with the Senate, with
7 colleagues on both sides of the aisle.
8 And I also look forward to hearing from the
9 administration, once they have a detailed balanced budget
10 plan.
11 The challenges before us, the opportunity we stand
12 to gain by making the right kind of reforms, demand the
13 best we have to offer. They demand a bipartisan spirit,
14 cooperation with the President, and a shared vision of a
15 future that will continue to bless the lives of all
16 Americans.
17 Senator Moynihan?
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S.
2 SENATOR FROM NEW YORK
3
4
5 Senator Moynihan. Thank you, Mr. Chairman. I
6 observed that our former Chairman, and our Majority
7 Leader, is here. I wonder if he would like to speak.
8 Senator Dole. No. I see you had a very good
9 article in the paper this morning. I liked that.
10 Senator Moynihan. Now that is my kind of Majority
11 Leader. He said I had a very good article in the paper
12 this morning, and he liked it.
13 I will just drop everything and talk about that
14 because I very much agree with the Chairman that we have
15 these spending trends, and we have to do something about
16 them.
17 I think it is important to get these numbers clear,
18 and they are very much bipartisan. Starting in 1972, we
19 in the Finance Committee indexed, as we say, the benefits
20 paid by Social Security to reflect increases in the cost
21 of living. It is a common practice across the OECD and
22 other countries.
23 Then, in the 1980's, we also indexed the income tax
24 brackets to offset the effect of bracket creep, again for
25 the cost-of-living index.

1 But the problem, as you know sir, is that there is
2 no cost-of-living index. What we used as the proxy was
3 the consumer price index, which is computed monthly by
4 the Bureau of Labor Statistics. And the Bureau of Labor
5 Statistics is emphatic in saying that the consumer price
6 index is not a cost-of-living index. For some time, it
7 has been understood how much it overstates the actual
8 cost of living.
9 As the Chairman knows, we held hearings last spring
10 on this. Then in June, Chairman Packwood and I appointed
11 an advisory commission that is headed by Michael Boskin
12 of Stanford University, who was Chairman of the Council
13 of Economic Advisers under President Bush. The
14 commission includes five nationally prominent
15 economists--maybe the only five who thoroughly understand
16 the subject, but they do, and they agree.
17 About 10 days ago, sir, you and I released their
18 interim report. Now these are huge numbers of vast
19 consequence. They say that the CPI overstates the cost
20 of living by from .7 percent to 2 percentage points.
21 Now to give you a sense of what that means, the CPI is
22 growing a little less than 3 percentage points a year.
23 If it overstates the cost of living by 2 percentage
24 points, that means that it doubles the actual cost of
25 living. No--it triples the actual increase in cost of

1 living. Yes, that would be reflected three times.
2 In any event, our commission, in effect, proposed 1
3 percentage point. Here is the power of these numbers.
4 One percentage point change, to effect a true cost of
5 living, which is the intent of our legislation, would
6 bring us $281 billion in 7 years. That is half the money
7 you need. In 10 years, it would bring you $634 billion.
8 In 15 years, you start getting into the trillions. I see
9 my friend from North Dakota, who was a tax commissioner
10 in his day, nodding.
11 In no time at all, you are into the trillions. That
12 is how much our outlays are higher than the law intends
13 each year, and our revenues are lower.
14 Mr. Ballantine, the Actuary at the Social Security
15 Administration, estimates that since 1972 Social Security
16 retirement benefits have been $300 billion higher than
17 the law intended, simply because of this miscalculation
18 we made.
19 If we can correct it, we will, first of all, get the
20 right numbers. We will be doing what we said we wanted
21 to do. Everybody will get an increase in their Social
22 Security check; everyone will see the income tax brackets
23 rise, but by a correct number.
24 If we could do this, we would free ourselves in so
25 many ways. Not that these matters do not need to be

1 addressed, but we have a large debt, we have people who
2 would like to see other things done, other programs,
3 other tax deductions. Here is real money, and a real
4 bipartisan opportunity.

5 The Congress has already incorporated a change in
6 the CPI for the budget resolution. The Majority Leader
7 of the Senate began by noting that Mr. James Glassman
8 said much the same.

9 I just hope that we do not miss an historic moment.
10 The Finance Committee has created this opportunity, Mr.
11 Chairman, and I hope we can make use of it.

12 The Chairman. Just let me say, Senator Moynihan,
13 that I strongly agree with you as to the importance of
14 this finding. It is something that not only deserves,
15 but demands a bipartisan follow-through.

16 Let me say that, as far as our immediate problem is
17 concerned, the rules are such that it does not help us.
18 As you pointed out, if this is put into effect, much of
19 any savings would impact upon Social Security. And, of
20 course, anything you do in the area of Social Security
21 would necessarily require not only bipartisan attention,
22 but the involvement, I believe, of the President as well.

23 I would certainly hope that you would suggest to the
24 President that it is important for us to get together to
25 determine exactly how we move ahead on this important

1 finding.

2 I would point out, of course, that this finding is
3 an interim finding, and they are going to come forth with
4 a subsequent recommendation. Obviously, we want to make
5 certain that anything we do is correct. A change of as
6 little as one-tenth of 1 percent has tremendous
7 ramifications over the years. So it is important that,
8 as we move ahead on this historically important finding,
9 that we do it in a responsible way, and not regret our
10 action later.

11 So I strongly agree that this is a critically
12 important study, and that we should decide in a
13 bipartisan manner what should be done as a result of the
14 recommendations coming forth from this commission.

15 In the meantime, we still have the responsibility of
16 meeting the challenge of the budget resolution, and we
17 hope to do that in the next several days.

18 Senator Moynihan. Could I just say, sir, that in
19 the 7-year projection, 35 percent of the $281 billion,
20 roughly $100 billion, is increase in revenues. That is
21 how powerful this is.

22 Mr. Samuels is here. Perhaps he will comment later
23 on, when we get to taxes.

24 I much agree that the President should be involved.
25 I am sure he will want to be involved.

1 The Chairman. Senator Dole?

2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF HON. BOB DOLE, A U.S. SENATOR FROM
2 KANSAS
3
4
5 Senator Dole. Thank you, Mr. Chairman.
6 I will just take a minute. First, I want to agree
7 with what has been said by the Chairman and by Senator
8 Moynihan.
9 We have looked at this over the years, and we have
10 always backed away from it because we did not have strong
11 bipartisan support, and maybe it did not have support
12 from the White House. For this to work, we have got to
13 be in it together, and the House has got to be on board.
14 They have already recognized it in their budget
15 resolution. Point 6, was it not? And we had .2.
16 Senator Moynihan. Yes, it was .6.
17 Senator Dole. So there has already been an
18 indication that we recognize that adjustments should be
19 made. And, in fact, they have indicated in the budget
20 resolution that they are going to make the adjustments.
21 But it will only happen if everybody sort of joins hands.
22 It seems to me that this is something we should have
23 addressed years ago, and I think that the commission that
24 was established has done a good job. So I certainly want
25 to particularly thank Senator Moynihan, and others who

1 have been looking at this for some time. I know Senator
2 Nickles has had an interest in it, and I know Senator
3 Breaux has had an interest in it. I know they have had
4 some discussion. But, hopefully, we can work on that.
5 I know it has already been done but, first of all,
6 since this is the first public meeting since Senator Roth
7 took the gavel, I certainly want to commend him for the
8 outstanding job he has done. He has had a very quick
9 transition. I do not think we lost but about one day.
10 Bill, I think you are off to a great start, and I
11 appreciate it.
12 The Chairman. Thank you.
13 Senator Moynihan. He got a good round of applause
14 earlier.
15 Senator Dole. Good.
16 Well, we have some tough decisions to make. Even
17 with the CPI as a possible aid somewhere along the line,
18 I think we do have to respond to the Medicare trustees'
19 report.
20 I am sitting here with Senator Moynihan, and he may
21 recall what happened in 1983. Social Security was about
22 to go down the tube. Ronald Reagan, a Republican, Tip
23 O'Neill, a Democrat, and Howard Baker put together this
24 commission. In the end, I think largely due to the
25 Senator from New York's efforts, we were able to rescue

1 Social Security. It is going to be good at least until
2 the year 2013, maybe 2020 and beyond. So it can be done
3 in a nonpartisan, bipartisan way.
4 Maybe it is too late for that at this point, because
5 I know reconciliation bills have a habit of being fairly
6 party line. But we do have a problem, we should fix it,
7 and that is what the debate is all about. I think four
8 out of five Americans now understand that we ought to fix
9 it, though certainly some seniors are concerned.
10 I think it is up to us, since we have the Majority,
11 to demonstrate that we are going to do it in a way that
12 does not adversely impact on senior citizens.
13 I recall my mother, who had only Social Security
14 income, that was it. She used to tell me every time I
15 would go home, do not touch my Social Security. There
16 are a lot of people across America in the same situation.
17 They are concerned that if we start touching Medicare,
18 something else may happen.
19 So it seems to me that we have a larger challenge.
20 That is, to deal with the deficit, and keep our word that
21 we will balance the budget by the year 2002. We had a
22 lot of debate on the balanced budget amendment. Many of
23 my colleagues did not believe that we would balance the
24 budget by the year 2002, and we have not done that yet.
25 But we are on the right track, so we have to make some

1 very difficult decisions. If they were easy, they would
2 have been made before. Somebody would have made the easy
3 decisions. So I think we cannot turn back; we have got
4 to go forward.
5 We believe that we strengthened Medicare by insuring
6 solvency of the trust fund for at least 10 more years.
7 It allows overall Medicare spending to continue to grow
8 at about twice the rate of inflation. And it gives
9 seniors more choices--choices that are currently
10 available in the private sector, to members of Congress
11 and others--which until now have not been there for
12 Medicare beneficiaries.
13 The Medicare choices, as described in the Chairman's
14 Mark, represent the first time since its enactment that
15 Medicare beneficiaries will enjoy the same range of
16 options and benefits available to Americans with private
17 plans. At the same time, changes are made in the
18 traditional Medicare program to allow it to operate more
19 efficiently.
20 So we have Medicare. And then we have Medicaid,
21 which is another very difficult program to address. We
22 have had the Federal Government in effect micromanaging
23 Medicaid ever since its inception 30 years ago.
24 We have all heard from our Governors, whether they
25 are Democrats or Republicans, asking for greater

1 flexibility, more innovation, more opportunities. And we
2 have had a number of discussions with Governors in both
3 parties. The Governors are very important. They
4 represent the people, and they are closer to the people.
5 We have been trying to determine how we can best
6 deal with Medicaid. It seems to me that there is a very
7 delicate balance, and I hope that we can come together on
8 that. Maybe we cannot do it in a bipartisan way, but I
9 hope we can.
10 I know that the Chairman and his staff have put a
11 lot of effort into creating a fair formula which slows
12 the rate of health care growth, while adequately
13 providing for the needs of low-income Americans.
14 The earned income tax credit is the third pillar
15 here. Here is a program that started off, as everybody
16 knows, in 1975 at $1.3 billion. It is going to cost
17 about $30 billion by the year 2000. I have got to
18 believe that we can make some changes in that program,
19 and I know that the Senator from Oklahoma, Senator
20 Nickles, has focused on this program a great deal.
21 I just hope, Mr. Chairman, as we make these tough
22 decisions, that we keep our eyes on the future, on the
23 next generation, and on the children and grandchildren.
24 By making difficult decisions now, we are going to make
25 certain that they have an appropriate standard of living,

1 and not a lower standard of living.
2 I thank the Chairman very much. I would ask that my
3 entire statement be made a part of the record.
4 [The prepared statement of Senator Dole appears in
5 the appendix.]
6 The Chairman. Thank you, Senator Dole.
7 Senator Baucus?
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM
2 MONTANA
3
4
5 Senator Baucus. Thank you very much, Mr. Chairman.
6 First, Mr. Chairman, I want to wish you a very
7 successful tenure in your new chairmanship, and all of us
8 join me. This Committee is usually operated in a
9 bipartisan manner. Unfortunately, it is a little less so
10 on this issue but, Mr. Chairman, I very much hope that in
11 the future you will continue to work as well as you
12 possibly can to continue the tradition of this Committee
13 on a bipartisan basis. I wish you well in your tenure.
14 I think it is important to remember the basic facts
15 on Medicare and Medicaid before we go into the details,
16 so I would like to start with a few basics.
17 First of all, it is important to remember that
18 Medicare operates as a trust fund. If health costs
19 continue to rise at the present rates, and our senior
20 population continues to grow as expected, the trust fund
21 will run out of money in 7 years. We need to find only
22 about $90 billion to put it on strong footing again.
23 Now that sounds bad; in some ways, it is bad. But
24 the fact is that the Medicare trust fund has never in
25 history had more than 14 years of solvency. We were down

1 to 5 years of solvency in 1982, 2 years of solvency in
2 1972, and the trustees have projected bankruptcy nine
3 times in 30 years.

4 So we take that chart over there, as dire as it is
5 supposed to be, the fact is that that chart has been
6 drawn nine times and, in most cases, the consequences
7 were much more dire than are projected on that chart.

8 In 1982 and 1972, the trustees said that the trust
9 fund would go belly up in either 4 years or 2 years, not
10 7 years, as is the case there. With $90 billion in
11 savings, the trust fund will be solvent for at least
12 another 10 years.

13 Again, we need only $90 billion in savings to keep
14 the trust fund solvent for 10 years. We are not in a
15 crisis, as some would have us believe.

16 The plan we are looking at today is altogether
17 different. It calls not for $90 billion in cuts, but
18 three times that, $270 billion in Medicare cuts, three
19 times what we need. Instead of fixing the basement, we
20 are about to blow up the house and put up a pup tent
21 where the house used to be.

22 In my State of Montana, we will lose more than half
23 a billion dollars in Medicare payments. Combined with
24 our share of the $182 billion in Medicaid cuts, we will
25 lose one-third of our Federal health dollars.

1 I will be offering some amendments on Medicaid
2 later. But for now, I would just like to raise basic
3 concerns. We stand to lose all Federal protection for
4 elderly people in nursing homes, at the same time as we
5 lose the money for 2,100 long-term care slots, as
6 projected by this plan, each one averaging about $38,000
7 a year.
8 And protection for elderly spouses is gone under
9 this plan. That is the law that says you cannot lose
10 your house or your farm when your husband or wife goes
11 onto Medicaid.
12 On Medicare, Montana's older men and women are going
13 to face higher premiums and higher deductibles. Younger
14 couples struggling with mortgage payments will have to
15 give up some of their income to pay their parents' new
16 hospital bills.
17 The consequences for providers--that is, hospitals
18 and doctors--will be even worse. Some of our rural
19 hospitals depend on Medicare for up to 60 percent of
20 their revenues--60 percent. So if these cuts go through,
21 three times what we need to keep Medicare financially
22 sound, rural Montana will lose hospitals. We will lose
23 the health services they provide. We will lose thousands
24 of hospital jobs. We will lose the economic stability
25 they provide for small businesses--grocers, gas stations,

1 small banks, farm supply stores and more.

2 And counties will lose the revenue base they need to
3 give our kids top quality education. It will be a
4 disaster in rural America.

5 As the Montana Hospital Association told me just
6 yesterday, "The Chairman's Mark proposes an unprecedented
7 and completely unacceptable level of spending reductions
8 in Medicare and Medicaid budgets over the next 7 years.
9 I do not have to tell you the impact such cuts will have
10 on hospitals. Montana's hospitals have already cut their
11 operations to the bone."

12 Some people talk about war on the West. This is war
13 on the West--war on rural West, on rural hospitals, rural
14 doctors and on our seniors.

15 Finally, I would like to call attention to the open
16 admission contained in this plan, and the Gingrich plan
17 as well, that the authors have no idea whether their plan
18 will work. They are guessing about how many seniors they
19 can herd off into managed care. If it is fewer than they
20 expect, the infamous belt tightening or, more accurately,
21 noose tightening clause comes into effect.

22 The noose tightening clause means that in any of the
23 next 7 years, our hospitals face the prospect of
24 unannounced massive new cuts in reimbursement. They will
25 not know about it. They will not be able to prepare for

1 it, and they will have to scramble to cut services and
2 lay off even more staff.
3 Finally, the reason for all this is obvious. We
4 have to save only about $90 billion. But instead, the
5 plan cuts $270 billion. That pays for $180 billion in
6 new tax cuts. And some of them will go to people who are
7 already quite well off, and do not need it.
8 So today we have a very clear choice, and it really
9 ought to be an easy choice. We could go ahead and cut
10 $270 billion out of Medicare. We can close rural
11 hospitals, and weaken a program that provides a guarantee
12 of health security for Americans as they approach
13 retirement. Or we can scrap a bad bill, shrink down an
14 unnecessarily big tax cut, and do the real work we need
15 to do to put Medicare on sound financial footing. I
16 think the right thing to do is obvious.
17 And I might add, as the Majority Leader said, in
18 1983 we saved Social Security by putting together a
19 bipartisan commission--Republicans, Democrats, public and
20 private sector. We got the job done, and we saved Social
21 Security on a nonpartisan, nonpolitical basis. I think
22 we should do that here.
23 Medicare has a few problems; it is not in a crisis,
24 but a few problems. Let us solve those few problems on a
25 bipartisan, nonpolitical basis, appoint the same kind of

1 commission, get the job done as seniors expect it to be
2 done, as hospitals and doctors expect it to be done, not
3 on an extremely partisan basis as here. Especially when
4 we are going to bleed Medicare, cut Medicare, not save
5 it, and use those cuts for programs that most Americans
6 do not want, not only the unnecessarily large tax cuts
7 for the most wealthy, but also paying for new defense
8 programs that the Pentagon does not want, the Joint
9 Chiefs of Staff do not want, and probably do not make
10 sense to most Americans today in the 1990's.
11 So again, Mr. Chairman, I say that the choice is
12 clear. If we are really honest with ourselves, if we are
13 really going to do what is right by Medicare, we do not
14 adopt this plan. Rather, we set up a commission, as we
15 did for Social Security, the Greenspan Commission for
16 Medicare. That is the way to get the job done. I know
17 my colleague, Senator Rockefeller, suggested this. I
18 think it is a good idea, and that is what we should be
19 doing.
20 Thank you.
21 The Chairman. Senator Chafee?
22
23
24
25

1 OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR
2 FROM RHODE ISLAND
3
4
5 Senator Chafee. Thank you, Mr. Chairman.
6 I want to join in the congratulations to you, your
7 elevation to Chairman of this Committee. We have had a
8 long series of distinguished chairmen of this Committee,
9 and we are delighted that you will be taking over. I
10 know you will do an excellent job.
11 I want to briefly comment on what Senator Moynihan
12 was talking about in connection with achieving an
13 accurate measure of the cost of living. I think we
14 should do that. I am not saying that we should do that
15 in lieu of attaining the savings required in the budget
16 resolution. I think we ought to do both. There is
17 nothing in the U.S. Constitution that says we cannot
18 start paying off the debt of this nation, and I would
19 like to see us start in that direction.
20 The challenge facing this Committee, beginning
21 today, is whether we will be able to make the changes
22 necessary to bring the Federal Government into balance,
23 to do our part of that.
24 It is a big task. As we pointed out, this Committee
25 has by far the largest portion of that task. I suppose

1 we have about 80 or 90 percent of the total savings in
2 this Committee. But it is the single most important step
3 we can take this year to markedly improve our country's
4 future.
5 If we want to do something for the nation, then
6 balance the budget. We cannot continue on the path we
7 are on, spending more than we take in, and sending the
8 bill to our children. Of every dollar the Federal
9 Government currently spends, 15 cents is borrowed.
10 Absent definitive action by this Committee, we can expect
11 to see annual deficits of $200 billion in the foreseeable
12 future.
13 Because of the horrendous national debt, $5
14 trillion, 15 percent of our budget is devoted solely to
15 paying interest on that debt. Not many people realize
16 it, but the third largest expenditure that this Federal
17 Government makes is interest on the debt. There is
18 Social Security, there is defense, and then there is
19 interest on the debt. I am talking interest, not
20 principal. We are not paying off a nickel of principal;
21 it is all interest on the debt.
22 Now today, as regards those spending measures which
23 are subject to the jurisdiction of this Committee, we are
24 embarking on some fundamental changes. Seven years from
25 now, as a result of those changes we and other committees

1 will make, we will end the practice of pushing today's
2 expenditures onto the backs of our children.
3 I want to commend the Chairman and the staff for
4 finding the $270 billion savings in the Medicare program.
5 It is very difficult to attain that target, but we have
6 to if this program is to be saved from bankruptcy, as has
7 been previously mentioned here today.
8 I think a good job has been done in striking the
9 right balance between controlling the growth in the
10 various parts of the Medicare program and the
11 difficulties that will be experienced by the
12 beneficiaries. I think the reforms offered to Medicare
13 will make it more efficient, and should provide better
14 service to our seniors.
15 That having been said, Mr. Chairman, I have serious
16 concerns about the Medicaid provisions contained in this
17 Mark. I think the Medicaid program, as it exists now in
18 our country, is fraught with problems--no question about
19 it. And the States do need increased flexibility. I am
20 for that flexibility that is needed to administer the
21 program in the face of rising costs.
22 But if providing flexibility means no longer
23 assuring that there is health care for the most
24 vulnerable populations, namely low-income children,
25 pregnant women, persons with disabilities and the

1 elderly, I do not think we are headed in the right
2 direction.
3 This is an expensive, stark proposal, Mr. Chairman,
4 in light of where we were just a year ago in the health
5 care debate. In 1 year, we have gone from an argument of
6 whether or not we will have universal health coverage to
7 an argument over whether or not pregnant women and
8 children living below the poverty line should be
9 guaranteed health insurance coverage. That is the
10 question.
11 Mr. Chairman, I do not believe this is the approach
12 we should be taking. I will be offering amendments to
13 provide some guarantees to low-income families and to
14 preserve our health care safety net. I am hopeful we
15 will be able to reach an agreement on some of those
16 critical issues.
17 Thank you, Mr. Chairman.
18 The Chairman. Thank you, John.
19 I do want to emphasize that our proposal does
20 require mandatory spending for the poor, including the
21 impoverished pregnant women, children, as well as the
22 elderly poor and, of course, the disabled. We have
23 provided assurance that there will be significant
24 spending in these areas.
25 At this time, I would like to call on my good

1 friend, Dave Pryor.

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR
2 FROM ARKANSAS
3
4
5 Senator Pryor. Mr. Chairman, I join with all of my
6 colleagues this morning in congratulating you, sir. I
7 look forward to working with you, as I know all of us do
8 on this side of the aisle and that side of the aisle too.
9 You are going to make a superb Chairman. I know that the
10 task before you, and the task and challenge before us, is
11 enormous. I hope we are up to the job, and I think we
12 are.
13 Mr. Chairman, I want to make probably two or three
14 observations about some of the issues that sort of jump
15 out at me with regard to the proposal as laid down last
16 Thursday or Friday by you and your colleagues.
17 First, Mr. Chairman, I would like to state that I
18 think we are totally going in the wrong direction when we
19 start to eliminate the nursing home regulations on the
20 Federal level.
21 One of my very first issues when I was a freshman
22 Congressman, many, many years ago, was to look at the
23 lack of Federal regulations regulating nursing homes to
24 protect our seniors living in those particular nursing
25 homes. It was a long battle, a very long battle indeed,

1 to reform the nursing home regulations, and to ultimately
2 come forward in OBRA 1987 with nursing home regulations
3 that meant something, that made a statement, where the
4 nursing home owners and the patients knew what the rules
5 were at the outset. Mr. Chairman, I think it is a
6 terrible tragedy for us to consider eliminating these
7 regulations.
8 The second area of concern I have with regard to
9 your proposal is in the Medicaid program. In the
10 Medicaid program, as a result of good work by Senator
11 Chafee in 1990, Senator Rockefeller in 1990, and
12 hopefully a little bit added by myself, we were able to
13 install--or I should say instigate--a drug rebate program
14 for the States, where the States could basically bargain
15 with the pharmaceutical manufacturers, and ultimately
16 find at the end of the rainbow a drug rebate, so that the
17 Medicaid programs would not be paying the highest price
18 for drugs of any entity throughout our provider system,
19 as they were pre-1990.
20 We eliminated this terrible situation, where they
21 were paying this exorbitant price for drugs for the
22 poorest of the poor. We gave the States a great
23 opportunity to participate in a rebate program. They did
24 participate and, as a result, this program, which is
25 working well and efficiently, which has saved $5 billion

1 over the past 5 years, we are now about to sunset it, if
2 not eliminate it under this proposal. As we say, we are
3 going to give it to the States as an option.
4 I do not think that is enough, Mr. Chairman. And I
5 respectfully do not believe that we can say to the States
6 that we are going to just cut you adrift, we are going to
7 make you continue as you did before 1990, paying the
8 highest prices for drugs for the poorest of the poor and
9 those who live in nursing homes today.
10 The third thing that I think we need to correct--and
11 I will cut this very short--we have an opportunity to
12 correct what I call an unjust enrichment that was
13 unfortunately and inadvertently created when we wrote
14 GATT, and signed GATT into law.
15 That is, of course, we extended to all of the drug
16 manufacturers an extra 3 years of patent protection under
17 the GATT proposal. What this meant was that some of the
18 drug companies now are going to have an opportunity, not
19 even planned for by themselves, for an extra 3 years of
20 protection with no generic competition whatsoever.
21 I know that Senator Chafee has talked to Chairman
22 Roth. I have attempted to, but did not make my
23 connection with him yesterday. But I am hopeful that we
24 can make this correction, and that we can solve this
25 matter so that this matter of unjust enrichment will not

1 occur.

2 Mr. Chairman, I have other comments, but I would
3 like to submit my formal statement for the record. I
4 thank the Chair for recognizing me.

5 [The prepared statement of Senator Pryor appears in
6 the appendix.]

7 The Chairman. The Chair would announce that the
8 complete statement of every Senator will be included as
9 if read. Needless to say, we look forward to working
10 with you.

11 The Chairman. Senator Hatch?

12 Senator Hatch. Senator Grassley is before me, Mr.
13 Chairman.

14 The Chairman. Senator Grassley?

15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S.
2 SENATOR FROM IOWA
3
4
5 Senator Grassley. Thank you, Mr. Chairman.
6 Over the next few days, we are going to be
7 discussing two very critical programs for all Americans.
8 These are the programs that have served from a health
9 standpoint the poor on the one hand, and the second
10 program the retirees of America.
11 However, they have been managed by the same business
12 as usual Government. I think the American people have
13 asked us in the 1994 election to reform. Our objective
14 is, and our objective must be, to bring improvements to
15 these two programs, to keep them viable, and serviceable.
16 But, if we do not do what must be done, these
17 programs are in big trouble, as we know they already are.
18 And our whole Government solvency, from a budget
19 standpoint, is in doubt.
20 Responsible Senators want to strengthen, and they
21 want to preserve Medicare and Medicaid. What stands in
22 our way are doomsayers who are out in force. It is
23 ludicrous to suggest, as some have, that reformers of
24 these programs, as we are, do not like retirees, and
25 somehow we hate the poor. A skeptic could say the same

1 thing about the inaction of people who suggest that we
2 continue business as usual.
3 Our listeners need to remember that both of these
4 programs are in financial difficulty. They spend a great
5 deal of money annually--Medicare $181 billion, Medicaid
6 $89 billion--of just Federal dollars.
7 I want my constituents to know that both of these
8 programs have been growing like Topsy in recent years,
9 and are expected to continue to do so. By this I mean
10 that they are growing by 10 percent per year; and that is
11 10 percent per year on a very large base. Medicaid has
12 grown much faster than that in recent years, and its
13 spending in the coming years is expected to increase
14 around 10 percent annually if nothing is done.
15 This spending pattern has brought the Medicare
16 program to the brink of bankruptcy. The Part A program
17 will be spending more per year in 1996 than it is taking
18 in. This is the first time in the history of the program
19 that that will be the case.
20 Under current law, this program will be bankrupt in
21 2002. Obviously, we will intervene to make sure that
22 that does not happen. But it indicates the severity of
23 the problem.
24 We can intervene now in a gradual way, and much
25 easier than if we want until it is totally bankrupt.

1 If we do not do that, we are going to be totally
2 irresponsible by waiting until the last minute. And, by
3 waiting until the last minute, it is going to cause
4 disruption, and it is going to cause needless hardship,
5 like the Congress did with Social Security in 1983 when
6 we waited for 18 months before intervention.
7 The Part B program is expected to grow by 14.3
8 percent and 13.4 percent this year and next. And this
9 spending pattern is not going to moderate in the near
10 future. Since most of Part B is paid for by general
11 revenues, the Part B program makes a direct contribution
12 to the deficit problem. And as the cost of this program
13 increases, beneficiaries even pay more, and they do it
14 without an act of Congress, but automatically.
15 Now we face this problem immediately--not out there
16 in the distant future. But we have to remember that in
17 just a few short years, the baby boomers begin to retire,
18 and we have an even bigger problem. Imagine the
19 situation when that happens, and what is going to face
20 them.
21 At this point, meaning 1995, 7 years before the
22 bankruptcy, we have time to do something about it before
23 we face the avalanche of retirees that will happen by the
24 year 2010. There is absolutely no way the program will
25 be able to continue in its present form, and take care of

1 those large numbers.

2 The situation we face in the Medicare program was
3 well summarized by the public trustees. I am not talking
4 about the members of the President's Cabinet, who also
5 unanimously said that this program ought to be fixed, I
6 am talking about the public trustees. They said this,
7 and I quote, "We strongly recommend that the crisis
8 presented by the financial condition of the Medicare
9 trust fund be urgently addressed on a comprehensive
10 basis, including a review of the program's financing
11 methods, benefit provisions, and delivery mechanisms."

12 I want to emphasize that these are public trustees,
13 appointed by the President of the United States. They
14 are independent of the administration. One is a lifelong
15 Democrat; one is a lifelong Republican. They have both
16 long been involved in retirement and health care
17 problems, so I believe their cautions must be taken
18 seriously. So that is why we are here today.

19 The budget resolution passed by Congress last Spring
20 was the first step in addressing this problem. That
21 resolution called for the moderation in Medicare and
22 Medicaid spending. The goal--our goal--is the
23 preservation of those programs. They are not going to be
24 there for those who need them unless we get the spending
25 in line with what the American people are willing to pay

1 for these programs.

2 The budget resolution calls for $270 billion in
3 savings from the Medicare program over 7 years. Now
4 these are substantial savings, and there is no doubt
5 about it. But I want to remind everybody, even with
6 these savings, Medicare is still going to be the fastest
7 growing program in the Federal budget. The total average
8 annual growth rate is going to be about 6.4 percent.
9 That is going to be about twice the rate of inflation.
10 Total Medicare spending is going to increase by 54
11 percent over the next 7 years. Medicare spending is also
12 going to increase on a per-capita basis at around 5
13 percent per year.

14 Some of us are having a hard time understanding all
15 this talk about a cut in a program when it grows at 6.4
16 percent, almost twice the rate of inflation. We hear
17 talk that it is about equivalent to destroying the
18 program. That is what some are alleging.

19 Now the need to address these problems is very
20 clear. It would be grossly irresponsible to sit on our
21 hands and do nothing about what we know is a problem that
22 has been defined very well by people that the President
23 of the United States, a Democrat, has appointed. But
24 that is what we are seeing in some areas.

25 There is kind of a sit-and-carp strategy. There is

1 a head-in-the-sand strategy. And I think it is
2 irresponsible. We must act, and that is why we have this
3 plan before us.
4 Maybe I ought to say wait a while. I recently read
5 the paper that there is another plan. Its author wants
6 to sit down and talk. That is it, that is the plan, sit
7 down and talk. We are ready to mark up this bill right
8 now, and others want to sit down and talk. Even the
9 Washington Post has called on the Democrats to put up
10 their own plan. To sit down and talk is not a plan.
11 We saw irresponsible people use exactly the same
12 strategy during the budget debate. First, our opposition
13 challenged us for not having specifics in that budget.
14 When we produced specifics, they attacked our specifics.
15 And when we asked where their plan was, they said, well,
16 let us sit down and talk.
17 That strategy will not fly with the American people.
18 They want answers to a problem that has been defined by
19 the President of the United States' own trustees of the
20 Medicare system. I will bet there are some who were
21 mightily surprised when the Washington Post took issue
22 with this strategy of no plan, no alternative. That is
23 because this is not, and should not, be a political
24 debate. It is a credibility debate and, unless you have
25 an alternative plan, there is no credibility.

1 Chairman Roth has proposed a bill which I think
2 moves in the right direction. It achieves the spending
3 slow-down in these programs called for in the budget
4 resolution. That in itself is a major achievement. It
5 begins a Medicare reform, and I am very cautiously
6 optimistic about the Medicare choice program outlined in
7 the Chairman's Mark.
8 This reform holds the promise of much greater choice
9 in health care arrangements for health care beneficiaries
10 than is presently the case. No longer will everybody be
11 in a straight jacket, on a Government-defined health care
12 program with no choice.
13 If this reform works, Medicare beneficiaries will be
14 able to choose a variety of health plans, like Congress
15 and Federal workers can, from medical savings accounts to
16 the usual fee-for-service plans and a variety of managed
17 care plans.
18 Medicare beneficiaries will also be able to remain
19 in the traditional Medicare program. They will be able
20 to keep doing things just has they have for the last 30
21 years, if that is what they desire.
22 I believe the Medicare choice plan also has the
23 potential to greatly increase the resources coming into
24 rural areas for health care, rural areas like my State of
25 Iowa.

1 If the Medicare choice payment formula is done
2 right, it will reduce the current very wide per-capita
3 payment differentials across the regions of America. The
4 low-cost rural areas should benefit greatly. For that I
5 am grateful. The per-capita payment formula contained in
6 the bill may be at long last begin to provide a fair
7 reimbursement for my constituents in Iowa.
8 But we need to be clear about one thing, Mr.
9 Chairman. That is that these per-capita payment
10 adjustments must work for our low-reimbursement States.
11 Whether the proposed improvements in Medicare per-capita
12 payments in low-reimbursement States like Iowa are big
13 enough, I do not know, Mr. Chairman. I hope they are. I
14 think they are. If they are, the reforms that your bill
15 expects will occur in States like Iowa. If they are not
16 big enough, the improvements we hope for are going to
17 pass us by, and States like Iowa will continue to be
18 starved of health care resources.
19 So while I am pleased with what your bill does, Mr.
20 Chairman, I do have a number of concerns about the
21 proposed Medicare reform. First, I would like us to do
22 whatever is necessary to make sure that the bureaucrats
23 in HHS implement the reforms the way that we intend.
24 I would also like, Mr. Chairman, to make sure that
25 the Congress will have an early opportunity to review the

1 reforms that we enact, and make any adjustments which
2 might be needed down the road, so that we know what we
3 decide today is carried out in the near and distant
4 future the way we intended, so that we do not somehow get
5 short circuited like we did with some reforms we made in
6 1984, that later turned out not to work the way we
7 intended that they work, particularly in low-cost parts
8 of the country.
9 Finally, I am also concerned that the look-back
10 sequester arrangements, which will be used if traditional
11 Medicare overspends, will be unfairly harmful in rural
12 America--I should say low-cost parts of America.
13 Many people will probably remain in traditional
14 Medicare programs. That is because we do not have the
15 resources right now to get the alternative choices into
16 our State. Spending in States like mine will probably
17 continue to grow more slowly than in many other areas.
18 So if a sequester is required, and if this sequester is
19 applied across the board, then States like Iowa could be
20 badly hurt, even though they are not causing the problem.
21 I would like to see something in the bill which addresses
22 that problem.
23 I am also pleased with the rural health provisions
24 which Chairman Roth has included in the bill. These
25 provisions are certainly going to help those who continue

1 to participate in the traditional Medicare programs in
2 States like mine.
3 These include an extension of the Medicare-dependent
4 hospital program, incorporating legislation that I
5 introduced earlier. They include a critical access
6 hospital program, incorporating legislation Senator
7 Baucus, Senator Rockefeller and I introduced some weeks
8 ago. And they include legislation that I have been
9 trying to get to the President for several years, for
10 reform of Medicare reimbursement for physicians'
11 assistants and nurse practitioners.
12 This Committee has always been receptive to my
13 efforts to enact this legislation, but we have
14 encountered difficulties in the House. In any case, I am
15 grateful to Senator Roth for including this in his Mark.
16 This is the first time it has been in a Mark by the
17 Chairman.
18 With respect to Medicaid, Mr. Chairman--and I will
19 not spend much time on this--I support the wish of most
20 of the Governors to have greater discretion over
21 management of the program. My own Governor in Iowa,
22 Governor Branstad, supports the movement to decentralize
23 Medicaid. The current program is entirely too
24 complicated, burdens the States with too many rules and
25 regulations, and is growing at an unsustainable rate.

1 Under your proposal, Mr. Chairman, Medicaid
2 continues to be a health care program for low-income
3 people. States must spend money on the program to
4 receive a Federal match. And there are minimum set-
5 asides for the three main population groups that will
6 provide a floor of protection for them.
7 I am afraid that I have to reserve judgment on the
8 Federal allocation formula for Medicaid until I get some
9 more information. I know that this has been a very tough
10 nut for the Committee staff to crack, and they need to be
11 complimented for trying to satisfy diverse needs on this
12 Committee. What they have come up with looks like it is
13 going to be good for my State, but we have not had time
14 to study the proposed formula. I will have to reserve
15 judgment and comment on that until I have a chance to
16 study it.
17 I yield.
18 The Chairman. Thank you, Senator Grassley.
19 I think it is important that all of you who
20 represent rural areas study our proposal carefully
21 because, as Senator Grassley pointed out, we have taken
22 some very significant steps to seek to meet their needs.
23 I would also say to my good friend that, as the
24 former Chairman of Government Affairs, which has
25 responsibility for organization, we shall certainly watch

1 to make certain that the bureaucracy in Washington
2 carries out the intent of this Committee.
3 Senator Grassley. Thank you.
4 The Chairman. Now I regret to say that my good
5 friend and colleague, Bill Bradley, cannot be here today
6 because of the illness of his mother. We all hope that
7 she makes a very speedy recovery.
8 Senator Moynihan. Thank you, Mr. Chairman.
9 The Chairman. At this time, it is my pleasure to
10 call on Jay Rockefeller.
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S.
2 SENATOR FROM WEST VIRGINIA
3
4
5 Senator Rockefeller. Thank you, Mr. Chairman. I,
6 along with others, welcome you to the chairmanship of
7 this Committee. Our offices are side by side, and I have
8 always found you to be a very fair, even, steady person,
9 and we share many common interests. This is a very hard
10 job, and it will be. And I wish you, as others have,
11 very well.
12 The Chairman. I appreciate it.
13 Senator Rockefeller. I do not get a lot of
14 pleasure from saying some of the things I have to say
15 this morning, and particularly not on the day of your
16 first hearing, Mr. Chairman. And I do not think we are
17 going to find this repeated that often in this Committee.
18 But the fact is that one of the Members talked about the
19 Democrats only talking.
20 We did not, any of us, get the proposal we are now
21 considering, and which we will presumably mark up on
22 Friday morning. There has been no discussion, no debate,
23 no understanding, no understanding still by the Senator
24 from Iowa or any of the rest of us, what the allocation
25 formula under Medicaid is going to be. That is not yet

1 known to us.

2 I believe this is the type of package that cannot
3 afford to be tossed out at the last moment. And
4 particularly this Committee, the Senate Finance
5 Committee, is known for careful deliberations and, even
6 at times, wise decision making, but at all times knowing
7 what we are talking about, knowing what the consequences
8 are, knowing what the effects are, not only on our
9 institutions, on our tax policies, health care policies,
10 but on people.

11 Senator Daschle and I wrote Dr. June O'Neill of CBO,
12 a week or so ago, and copies of the letter will be
13 distributed to the Members at the conclusion of my
14 remarks. We asked her to try to estimate the effects on
15 beneficiaries of what is proposed in this proposal,
16 insofar as we know what is in this proposal.

17 I think that is something that should be done. I do
18 not think you can go ahead and make decisions without
19 knowing what additional out-of-pocket costs are going to
20 be for beneficiaries. I just do not think you can do
21 that. I need to know, in terms of my own people in West
22 Virginia.

23 I have to believe that, in the case of this program
24 that is being put before us today, the decisions were in
25 essence made a long time ago. They were made when the

1 Contract for America was submitted to the American people
2 by Speaker Gingrich, and agreed upon by members of the
3 Majority party on this side.
4 This is not just an effort to balance the budget,
5 and it is partly that. It certainly is not an effort to
6 solve the Medicare trust fund because it is much more
7 than that. I will get into that in a moment. It
8 certainly is an effort to create a $245 billion kitty of
9 money. You could not do it without the Finance
10 Committee, which is why I suspect that, when this is all
11 over and done, this will be a party line vote. This is
12 tragic because that means it has sunk to criteria which
13 are unworthy of this Committee.
14 But you are trying to get $245 billion for a tax cut
15 for a few folks, and you cut $270 billion out of
16 Medicare, and you do not need to cut any more than $89
17 billion, and we all know it. We cannot answer the
18 question, how about the other $181 billion that is being
19 cut? For what purpose is that being cut? There is no
20 answer.
21 With respect to making Medicare more solvent, I find
22 that highly disturbing. I agree with the Senator from
23 Montana when he said that the trustees of the trust fund
24 have declared Medicare to be bankrupt on many occasions.
25 We always come through and fix it. In fact, as the

1 Ranking Member well knows, in 1993 we cut--yes cut--
2 Medicare by $56 billion, and thus postponed by 3 years,
3 maybe 4 years, problems in the Medicare system.
4 Now we have a $270 billion cut--not $56 billion but
5 $270 billion--and this buys us 5 more years, 5 more
6 years, 3 or 4 years for $56 billion, 5 for $270 billion.
7 Obviously, it does not add up. And then we add more
8 money on defense spending, and we savage Medicaid $182
9 billion in what I consider the single cruelest, most
10 callous proposal before this Committee.
11 We take the earned income tax credit and savage it--
12 savage it. The earned income tax credit is easy to pick
13 on because relatively few people understand what it does,
14 but do not tell that to 100,000 families in my State of
15 West Virginia because they are working hard and trying to
16 stay above the poverty level. They could get on welfare
17 but refuse to get on welfare, maybe making less money
18 than they would be if they were on welfare.
19 It is not a pretty sight. And we do all of this
20 with a maximum of maybe 2 days of discussion, with so
21 many of us around the table, which means that only a few
22 questions can really get asked.
23 So I am concerned about this. I do not think this
24 Committee should ever do anything without knowing exactly
25 what we are doing, and I do not think we do now. I think

1 some do, and I think that the reason for all of this, as
2 I said, was set months ago with the Contract for America.
3 When it comes to Medicare, again, no matter what you
4 think, all we need is $89 billion. Eighty-nine billion
5 dollars will fix Medicare, fix the Medicare HI trust
6 fund. It will fix it. But we have $270 billion. That
7 leaves $181 billion. Not one dime of that will go to the
8 trust fund. So why are we doing that?
9 I think today, and maybe tomorrow, we will actually
10 have a chance to ask questions on behalf of seniors and
11 the disabled, other families in our States--in my case
12 West Virginia--about what the effect of cutting Medicare
13 is on them.
14 My immediate reaction is to ask where are Harry and
15 Louise, now that we really need them? I see changes
16 being proposed that will increase health care costs for
17 seniors. We did not know that until Friday, and we did
18 not know that until our side of the Committee, the
19 Democrats on the Committee, peppered the witness table
20 with questions which caused the witness table to have to
21 come out with some of the savings, which were not at that
22 point listed in the document. So we now know that there
23 are going to be increased out-of-pocket costs for
24 seniors.
25 I think this will mean that many seniors will cease

1 to be able to see their own doctor. I consider that
2 extremely serious. The majority talks a great deal that
3 they will be able to see their own doctor. Yes, for
4 substantially more money. On the other hand, getting
5 seniors into HMO's is a real beacon of this effort. When
6 you go into HMO's, you do not necessarily get to see your
7 own doctor. We all know that has been true since HMO's
8 were started. People adjust to that, but is it reform?
9 In fact, I looked up "reform" in Webster's
10 Dictionary. The description of reform is "to put or
11 change into an improved form or condition; to put an end
12 to an evil by introducing a better method or course of
13 action."
14 Now Medicaid is radical. The cuts in Medicaid are
15 radical. Again, the paper we got on Friday, 4 days ago,
16 I think means that kids are not going to have to get
17 immunized.
18 Yes, it turns over everything to the States. And,
19 yes, there are Governors in this country who have shown
20 through their actions over the years that they are, for
21 example, willing to set eligibility for AFDC or Medicaid
22 at 16 percent of the level of poverty. This means that
23 somebody making $2,000, let us say, might qualify. But
24 somebody making $2,300 would not qualify for Medicaid if
25 it was in the hands of the Governor.

1 Governors set eligibility standards now, and some of
2 them do so with a very harsh eye towards the poor. As is
3 sometimes said by people, not very publicly, the poor do
4 not vote very much. I hope that has not been a factor.
5 I think I have come to understand one thing about
6 this now. In 1987, in the nursing home reform provisions
7 that we passed in OBRA 1987, the Finance Committee said
8 that you could not restrain, tie down, shackle or drug a
9 nursing home patient. This repeals all of that. It says
10 that you can. It does not say you cannot. Why would
11 that be in there? I have no idea. I am certainly going
12 to ask the question. Could it be that it means you could
13 have fewer employees looking over patients in nursing
14 homes? Therefore, fewer employees, since they could
15 provide less care, would restrain or drug a patient so
16 that they would become placid.
17 There are 50 new sets of State regulations, with no
18 Federal minimum requirements, in the proposal before us.
19 HCFA waiver processes are repealed. The 1115 waiver for
20 Statewide demonstrations is repealed. Managed care
21 waivers are repealed and, I believe, not replaced by any
22 managed care quality standards to make sure that we do
23 not get a rash of poor people's HMO's. I worry about
24 that. And, of course, Medicaid repeals Title XIX and
25 block grants unlimited power to the States.

1 West Virginia will lose one-third of its Medicaid
2 funds, cutting into the lifeline for over 160,000 of our
3 children, over 6,000 of our nursing home residents and
4 their family members.
5 I feel very strongly about nursing homes. Nursing
6 homes rely exclusively on Medicaid, except for a very
7 small amount of private payment.
8 My mother died from Alzheimer's over a period of 8
9 to 10 years. Because my sisters and I were able to
10 afford the best kind of care for her at home, we could
11 provide her with that. Had we not been as fortunate as
12 we are, my mother would have been in a nursing home at,
13 in West Virginia about $38,000 a year, in California at
14 about $85,000 a year. We would not have been able to
15 afford that in other conditions.
16 With the cuts in Medicare, what would have happened
17 to my mother? Alzheimer's, in case you are not familiar
18 with it, is not a pretty way to die. It is slow, it is
19 24 hours a day, there is no let up. The pain on the
20 family is extraordinary. It wipes out not only the
21 finances of the individual who has it, but that
22 individual's children and grandchildren. It will do so
23 almost every time unless you are "lucky" enough to get it
24 in your mid-fifties, in which case your lifespan will be
25 very short and you might not have to go to a nursing

1 home.

2 Finally, let me just say on the earned income tax
3 credit, it is, if anything, under siege. I do not
4 understand why Republicans want to tax working families
5 into poverty by slashing the EITC, but they seem to. I
6 need to know why.

7 Until recently, the earned income tax credit was a
8 bipartisan program. President Reagan called it "The best
9 anti-poverty, the best pro-family, the best job creation
10 measure to come out of Congress." Now it seems that
11 everything is different.

12 And is it not interesting that Republicans are
13 suggesting increasing taxes by $40 billion on Americans
14 who earn $28,000 or less, and cutting almost $248 billion
15 in other taxes, mostly for taxpayers earning over
16 $100,000.

17 EITC is not welfare. EITC is not exploding, I would
18 say to my colleagues on the other side. It is not
19 growing out of control. Congress specifically voted what
20 is now happening to EITC. It was part of the 1993 budget
21 agreement. EITC is suppose to expand dramatically until
22 next year, fiscal 1996, and then it is going to level
23 off. It is designed to provide those who work hard, who
24 forego health insurance when they could have it through
25 Medicaid, in order to work, to live out the American

1 dream, to do right, to play by the rules, as they say.
2 It is an incredible program. It is being slashed, and I
3 do not understand why.
4 As I indicated earlier, 100,000 families in West
5 Virginia who get to keep more of what they earn will now
6 lose it. And I do not understand it. Everybody in this
7 room knows that owning a house leads to mortgage
8 deductions. Everybody on this Committee and every
9 businessperson knows that eating out can mean a meal or
10 an entertainment deduction, while the millions of hard-
11 working struggling parents in America, with incomes below
12 $27,000, just as clearly know that when they play by the
13 rules they will be rewarded up until now with something
14 called an earned income tax credit.
15 Budgets always reflect priorities. I think
16 priorities are very dangerous in this package. It is
17 deeply disturbing to me, representing not only the State
18 of West Virginia, but also as a United States Senator.
19 I hope the process ahead will get us on a better
20 course through questions that we ask. Again, I resent so
21 much of this $450 billion in Medicare and Medicaid, not
22 to speak of EITC, essentially being done to fulfill the
23 terms of the Contract, especially with respect to the
24 crown jewel of the Contract, and that is to give a tax
25 cut to the special few. Medicare and Medicaid folks will

1 just have to work things out on their own.

2 I will close with this statement. It has been said

3 that Medicare and Medicaid seem to be growing so much

4 faster than other things in American life. Of course

5 they are, because it is called health care. More people

6 are living over 84. That is the fastest growing part of

7 the population in Senator Bob Graham's State, and that

8 will be true in all of our cases very quickly.

9 The cost of technology is an enormous part of that.

10 You cannot treat health care like you treat bread.

11 People want the best health care. People demand the best

12 health care. It is a different commodity.

13 I worry, Mr. Chairman, even as I wish you well.

14 I thank you.

15

16

17

18

19

20

21

22

23

24

25

1 The Chairman. Well, I have listened to you very
2 carefully, Senator Rockefeller. But I guess the question
3 really is to those of you who do not like what we are
4 proposing, what is your plan; how are you going to save
5 Medicare and Medicaid? Our goal is to save these programs
6 and strengthen them.
7 The Washington Post, in a very interesting series of
8 editorials, have talked about the medagogues. It points
9 out in one editorial about the Republicans. It says, they
10 have a plan. Enough is know about it to say it is
11 credible, it is gutsy, and in some respects inventive, and
12 it addressed a genuine problem that is going to get worse.
13 The editorial says, what the Democrats have, instead, is a
14 lot of expostulation, TV ads, and scare talk.
15 My challenge to each and every one here is, what are
16 you going to do to save and strengthen these programs that
17 are so critically important for health purposes? You
18 cannot just talk about this group or that group because if
19 we do not save the basic programs there will not be help
20 for any of the beneficiaries or the providers.
21 Senator Rockefeller. Mr. Chairman.
22 The Chairman. I would just point out, and we have to
23 move on, Senator Rockefeller, that the President, too, has
24 proposed a tax cut. In this editorial it says the
25 Democrats have fabricated the Medicare tax cut connection

1 because it is useful politically. It allows them to attack
2 and to duck responsibility both at the same time, and we
3 think it is wrong.
4 I now call on Senator Hatch.
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF THE HONORABLE ORRIN G. HATCH, A U.S.
2 SENATOR FROM UTAH
3
4 Senator Hatch. Thank you, Mr. Chairman.
5 Congratulations on your Chairmanship. I also enjoyed
6 Senator Moynihan's article this morning in the paper. I
7 think it is very thoughtful and very reflective.
8 I guess I approach this a little differently from a lot
9 of people, because I was Chairman of the Labor and Human
10 Resources Committee and Ranking Member after that, really
11 the largest authorizing committee in the Congress,
12 somewhere estimated around 3,000 programs.
13 In all the time I served there our friends on the other
14 side never once asked, where is the money going to come
15 from to pay for these programs? They just added program,
16 after program, after program. I have heard $89 billion is
17 all it is going to take to save Medicare. I know that my
18 colleagues are sincere when they state that.
19 But this is just not a Medicare problem we are facing
20 today in this country, it is across the board. This
21 country is in trouble. And it is not just the savings we
22 would like to make by reforming and saving Medicare here,
23 it is the savings we have to make in programs throughout
24 the government by reforming and saving them as well, and in
25 some cases getting rid of some programs.

1 Medicare and Medicaid have been tremendously successful
2 programs, by anybody's measure, providing lifesaving and
3 life-sustaining services to literally millions of persons
4 over the last three decades. These programs, in my
5 opinion, need to be continued. But let us be honest about
6 it. Let us not just, as The Washington Post says,
7 medagogue this issue.
8 The Board of Trustees for the Medicare Federal Hospital
9 Insurance Trust Fund, which is made of up six people, four
10 of whom are cabinet members of this administration: Robert
11 Rubin, Secretary of the Treasury, Robert Reisch, Secretary
12 for Labor, Donna Shalala, Secretary of Health and Human
13 Services, and Shirley Chater, Commissioner of Social
14 Security.
15 On April 3rd, these trustees found, number one, for the
16 first time--for the first time in the program's history--
17 the Medicare Hospital Insurance Trust Fund will spend more
18 money than it takes in next year. The first time.
19 This is not something that just can easily be tinkered
20 with and fixed again. Even if you look at the graph of the
21 Chairman, it is pretty clear that even with what we are
22 doing it is not necessarily a total fix of this program.
23 It certainly slows the rate of growth so that there is hope
24 we can find other ways of correcting the program.
25 If you read the Chairman's mark, there are all kinds of

1 reforms and approaches that literally ought to help us to
2 not only slow the growth of the program, but get the
3 program under control and make it function better for more
4 people in better ways.
5 So, number one, for the first time in history Medicare
6 is going to go into bankruptcy next year. Number two, by
7 the year 2002, the Health Insurance Fund will have depleted
8 its surpluses and will be completely broke if we do not do
9 something about it. At that time, Medicare hospital bills
10 will no longer be paid.
11 Number three, Medicare Supplemental Medical Insurance
12 Trust Fund, that is, Part B, which pays for physicians and
13 other related services, is also unsustainable and payments
14 will soon be jeopardized as well. They found that the
15 average two-earner, 63-year-old couple retiring today will
16 consume about $117,000 in Medicare benefits more than they
17 pay into the program over their remaining retired life.
18 That is giving heartburn to young people all over this
19 country. Who is going to pay for that? It is going to be
20 the three and a half workers for everybody on Medicare
21 today that is going to pay for it, and that number of three
22 and a half is going down as seniors are becoming more in
23 number than the workers in our society. Yet no one wants
24 to let our seniors down. We have got to reform this
25 program.

1 I might mention that I get a little tired of this
2 business of cuts because this program is going up from
3 $4,800 average per person today on Medicare, 37 million
4 people, 4.5 million persons with disabilities, to $6,700
5 per person over the next seven years, regardless. If we
6 choose the Chairman's mark, it is still going to go up. It
7 is going to go up an average of over six percent a year.
8 So, those are hardly cuts.
9 But this program is more than just restraint of growth.
10 This program has a lot of suggestions as to how we might be
11 able to make Medicare and Medicaid work better in the
12 future. Now, I think the Chairman's mark is off to a good
13 start. I want to congratulate him.
14 This is not easy, especially when it seems like there
15 is no great desire to come up with a bipartisan solution.
16 We do not prefer that. I would prefer to see us work
17 together and solve these problems, but that is not the way
18 it is working out. We have not had any plan from the other
19 side other than, $89 billion will save this. Well, give me
20 a break. That will not save it.
21 We are going to have to change the program and we are
22 going to have to make it so it is saveable, and we are
23 going to have to make it so that our seniors have some hope
24 here in the future, and we have got to do it within
25 budgetary restraints.

1 Within the next couple of weeks one of the biggest
2 battles we have here is going to be whether or not we lift
3 the debt ceiling to $5.5 trillion going to $10 trillion.
4 If we get to $10 trillion, what difference is it going to
5 make? The dollar is not going to be worth anything anyway.
6 We have got to stop it now, this runaway train that is
7 eating us all alive and really audibly going to demolish
8 our seniors. I give the Chairman credit for at least
9 trying. I am not happy totally with each and every
10 provision of his mark.
11 I am concerned about the impact of these changes on the
12 provision of services in several areas, including nursing
13 home care, laboratory services, durable medical equipment,
14 things that I have worked on my whole Senate career.
15 I also want to ensure that we are continuing the proper
16 incentives for physicians to continue to practice. If we
17 do not do this right, there are not going to be any
18 incentives to go into the medical profession in the future
19 like there are today.
20 There will always be some incentives, I guess, but
21 nothing like today. We want hospitals and community health
22 centers to provide the vital services they do and continue
23 to be able to do so. We know that we have to have those.
24 We want home health agencies to be able to continue to
25 work. How many of you have had seniors in your family that

1 have been at home that could not have gotten by but for
2 home health care? It is something that I have worked on
3 every day I have been here since 1976. It is very, very
4 important. We want their compassionate care to those who
5 remain at home.
6 I want to make sure that we provide the proper support
7 for most rural and urban areas which could be affected by
8 dramatic changes in our system. My goal is to make sure,
9 as the bill moves through the process, that these and other
10 components of Medicare and Medicaid are treated as fairly
11 as possible.
12 But the game is over. We just cannot continue down the
13 same paths we have been going and just say, well, let us
14 fix it here, let us fix it there, and let us forget
15 everything else. It is not the way it is. We have got to
16 face reality. The Chairman is doing that, and others are
17 doing it.
18 I wish there were simple solutions, I really do. It is
19 a lot more fun to spend money around here. It is a lot
20 more fun to come up with these exotic, wonderful,
21 compassionate programs around here. You get a lot more
22 credit for it than you do for trying to save them and
23 reform them, and to make them work better, and to solve
24 problems. Well, we are at the point where we have to do
25 that.

1 My message is really simple. I wish we lived in a
2 world with unlimited resources: we do not. Our country
3 does not have unlimited resources anymore, and we have
4 unlimited demands. They are upon government to solve every
5 problem, and to the extent that we can, we ought to. We
6 have got to work together to get those problems solved, and
7 I hope that we can. We are living in a world of scare
8 resources in many respects.
9 The bottom line is, we have to be as fair as we
10 possibly can under the circumstances to our senior citizens
11 and to those persons with disabilities that we know cannot
12 help themselves and others who are having difficulty in our
13 society, and above all to our children.
14 Left out of this debate sometimes is, what happens to
15 the children who are going to be the two workers for
16 everybody on retirement sometime into the next century?
17 How are they going to pay for it all if we do not solve
18 these problems now, and if all we keep saying is, well,
19 this will do it here, this will do it there, but we do not
20 look at the problems overall and do what really has to be
21 done.
22 On EITC, I am a strong supporter. On the other hand,
23 do not tell me it is not running out of control, it has
24 gone up 1,100 percent in a relatively short period of time.
25 Some estimate as much as 40 percent of it is fraudulent.

1 It is time that we face that problem, face it down, do what
2 has to be done, while at the same time meeting what my good
3 friend from West Virginia is so concerned about, as am I,
4 the needs of people who really are poor and are really
5 having a difficult time.

6 Last, but not least, with regard to tax cuts, I do not
7 think we are going to have $248 billion in tax cuts. I do
8 not think anybody thinks that. But I also know that there
9 are some tax rate reductions which can lead to a stimulated
10 economy, to more revenues, which can lead to more jobs and
11 more opportunities, and we ought to be intelligent about
12 that, too.

13 This is not just a taxing body, this is a body that can
14 bring relief where relief really is needed. And I think we
15 ought to be thoughtful and reflective in doing that, and I
16 hope we will work together in doing that rather than just
17 go all one way or all the other.

18 I respect everybody on this committee. It is a great
19 committee. It is one reason why I left the Labor Committee
20 to come over here. That is a great committee as well. I
21 think that this committee, generally, works well together.
22 This is an area where we need to work together.

23 I know that it is going to be difficult, but I hope
24 that we can. To the extent that we can correct the
25 Chairman's mark, make it better, improve it, refine it,

1 reform it, I am all for it. But I really have to give him
2 a lot of credit, him and his staff, for the work that they
3 have done.
4 Thank you, Mr. Chairman.
5 The Chairman. Thank you, Senator Hatch. Time is
6 moving on, and I do not want to cut anybody off. But I
7 certainly would appreciate, to the extent that each one
8 can, to keep the remarks relatively short. Your full
9 statements, of course, will be included as if read.
10 Now it is my pleasure to call on Senator Breaux.
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF THE HONORABLE JOHN BREAUX, A U.S.
2 SENATOR FROM LOUISIANA
3
4 Senator Breaux. Thank you very much, Mr. Chairman.
5 I thought that when the committee was called to order by
6 the distinguished Senator from New York this morning that
7 there had been a coup and that we had taken over. Then I
8 thought that that might not be a good idea at this time, to
9 take over.
10 I look forward to working with you as Chairman. I look
11 forward to working with you as Chairman. I think that you
12 bring a long history in the finance area, and many
13 innovative thoughts and ideas. Hopefully we will be able
14 to work together on many issues down the line.
15 With regard to this proposal, however, Mr. Chairman, a
16 choice between bad options is not a choice, and this
17 proposal is a list of bad options. Let us be clear about
18 this proposal, that was conceived and born, not here, but
19 in the other body, really is all about.
20 It cuts $270 billion out of Medicare for elderly
21 citizens in this country, it cuts $182 billion out of
22 Medicaid programs for poor people in this country, in order
23 to pay for a $245 billion tax cut that is part of the
24 budget, again, that was conceived in the other body and
25 unfortunately adopted in this body.

1 This is not a policy proposal, it is a money proposal.
2 It is little more than more bureaucratic regulation,
3 designed not to reform, but to squeeze money out of health
4 care programs for the people of this country. It is status
5 quo. It is not bold policy innovations, which this
6 committee should be looking at.
7 Medicare and Medicaid cannot, must not, should not, be
8 used as a piggy-bank to fund tax breaks. Unfortunately,
9 the budget instructions that are before this committee are
10 very clear. It requires us to cut $450 billion out of the
11 programs that we have jurisdiction over.
12 Unfortunately, once these budget cuts and health
13 programs are certified by the Congressional Budget Office,
14 we are going to come back to this committee and spend those
15 tax savings, those cuts, in order to pay for tax cuts that
16 no one is really demanding, and I think are extremely
17 unwise to make in a time of huge budget deficits.
18 I know of no one that I have spoken to that suggests
19 that these tax cuts that are a part of this budget are
20 essential, necessary, or even wise at this time. Some
21 claim--and we have heard comments this morning--that we
22 have to cut $270 billion out of Medicare in order to save
23 it. That is like saying, we have to kill it to make it
24 well.
25 Mr. Chairman, we have a number of experts who differ

1 with that proposition. I have here an August 2nd, 1995
2 letter from Richard Foster, Department of Health and Human
3 Services' Chief Actuarial Officer, who looks at the
4 numbers, not through Republican glasses nor Democratic
5 glasses, but through an economist's glasses. He says very
6 clearly that the $89 billion in spending reductions would
7 ensure that the trust fund would be solvent through the
8 fourth quarter of the calendar year 2006; $89 billion, not
9 $270 billion.
10 That document is additionally supported by an August
11 3rd letter of 1995 by Bruce Vadlick, who is the head of the
12 Health and Human Services Administration that clearly says
13 that the President's plan would extend the life of the HI
14 trust fund from the year 2002, which is the estimate of
15 when it would be spending more than it takes in, through
16 the calendar year 2006, fourth quarter, with $89 billion in
17 reduced spending, not $270 billion.
18 Mr. Chairman and colleagues, I think that this proposal
19 puts the cart before the horse. We have a budget that has
20 come up with a number, a number that is needed in order to
21 pay for tax cuts. There is no policy with regard to that
22 number, it is just a number.
23 Instead of doing the policy changes first, implementing
24 those policy changes and seeing what reductions and savings
25 we can achieve, we have done it backwards. This proposal

1 says we need to find $450 billion of cuts, and hopefully
2 you can find some policy that will achieve those cuts.
3 That is doing it backwards, not the right way.
4 So, Mr. Chairman, when I look at what this would do in
5 my own State of Louisiana, it is terrifying. One hospital
6 group told me that this proposal will spell disaster for
7 Louisiana's rural health care providers.
8 The additional cuts called for in the mark will likely
9 result in the closure of many small rural hospitals. For
10 example, the plan calls for just one hospital, East
11 Jefferson General Hospital in New Orleans, to lose nearly
12 $120 million over the seven-year period.
13 The plan says, well, seniors will be able to stay in a
14 fee-for-service plan if that is what they would like to do.
15 I would suggest that, with hospitals like East Jefferson
16 losing $120 million over the period, what type of fee-for-
17 service are we going to have left?
18 Medicare and Medicaid already reimburse providers less
19 than it costs to provide the services; 89 percent of the
20 costs of Medicare services, 93 percent of the costs of
21 Medicaid services. With $270 billion of additional
22 Medicare cuts and $182 billion of additional Medicaid cuts,
23 what type of fee-for-service hospitals are we going to have
24 left, and how many are going to be left with that type of
25 a cut with no real policy changes?

1 An additional problem that strikes me is very
2 unreasonable, that even if these severe cuts, as bad as
3 they are, do not achieve the magical number that someone
4 has come up with, it gets even worse because there are
5 provisions in this plan which would trigger automatic
6 across-the-board cuts without Congress' involvement if this
7 document does not produce the savings that we hoped it
8 would produce.
9 If under this plan, for instance, managed care--which
10 I support--does not produce the $50 billion in savings that
11 someone says they expect it to produce, more severe cuts
12 would automatically occur without Congress' intervention,
13 further cutting payments to doctors and hospitals when we
14 ask them to do more.
15 So what do we do, do we just criticize their plan, do
16 we sit and let them criticize us for not having a plan?
17 What do we do with this tremendous problem that affects so
18 many people in this country?
19 Tomorrow the Democratic Leadership Council and our
20 Progressive Policy Institute will release a document. It
21 will be called "A New Deal for Medicare and Medicaid." It
22 will be a recommendation for comprehensive health care
23 reform, which we tried to do two years ago and many people
24 said, we do not have a problem. We should have done it two
25 years ago; we did not. We have an opportunity to look at

1 doing it again this time if we work together.

2 Let me just quote one thing that the document tomorrow
3 will say about the current system and how bad it is. "The
4 health entitlements in the current system are profoundly
5 archaic programs governed by arbitrary policy and budgetary
6 goals, managed by command-and-control regulation, and
7 reproducing their own enormous inefficiency throughout the
8 entire health care system in this country.

9 Furthermore, the current Medicare and Medicaid programs
10 constitute an immovable obstacle structurally, fiscally,
11 and politically to the progressive goal of ensuring all
12 Americans access to health care." That proposal will be
13 unveiled tomorrow.

14 So what does this committee do--and I will conclude
15 with this--to bring about the fundamental reform? I
16 suggest two things. Number one, we should fix the short-
17 term problem. It is an $89 billion problem that gets us
18 to the year 2006. Fix the short-term problem. We can get
19 together on how to do that.

20 Second, I think we are going to have to do something
21 differently. I think it is going to take the establishment
22 of a bipartisan health care reform commission with
23 Democrats, with Republicans, with experts that understand
24 where we are headed, in order to make recommendations that
25 will represent fundamental change in this system, not a

1 mere status quo tinkering around the edges.

2 I would hope that, in the course of this debate, with
3 the President's involvement, that we can reach that goal
4 which I think is what the American people want us to reach.

5 Thank you.

6 The Chairman. Senator Breaux, we welcome new plans.
7 I hope you will submit it to CBO so that they have an
8 opportunity to cost it out.

9 Just let me make one observation, because people keep
10 talking about cuts, when, in fact, that is not the case.
11 Medicare will continue to grow at an annual rate of 6.3
12 percent. I tell you, a lot of blue collar workers would
13 like to have that kind of increase every year. Medicaid
14 will increase roughly 4.9 percent. So we are talking about
15 slowing down the rate of growth.

16 This country just cannot continue to afford the rate of
17 growth that we have experienced in these programs the last
18 several years. I have noted that many outsiders, including
19 The Washington Post, New York Times, and others, agree with
20 that.

21 It is my pleasure now to call on my good friend,
22 Senator Simpson.

23

24

25

1 OPENING STATEMENT OF THE HONORABLE ALAN K. SIMPSON, A U.S.
2 SENATOR FROM WYOMING
3
4 Senator Simpson. Mr. Chairman, I thank you very much.
5 I greatly look forward to working with you and Senator
6 Moynihan. I have been privileged to serve with both of you
7 on various committees over the years and it has been a
8 great pleasure.
9 Well, it is certainly a nice year to come on the
10 Finance Committee. It has been quite a joyous experience
11 for me, because I served on the bipartisan--and it was,
12 indeed, bipartisan--commission. But nobody paid any
13 attention to it, because it was too honest.
14 It was the bipartisan commission with regard to the
15 entitlements programs of the United States. Senator John
16 Danforth and Senator Bob Kerrey were the co-chairs, and 32
17 of us on the commission agreed with this scenario.
18 If we do not "do something dramatic," in the year 2013
19 every single bit of revenue in the United States, at
20 present levels without any increase in taxes and having
21 done a "perfect health care bill"--which is certainly the
22 dream of the age--will be going only to four programs in
23 the United States. It will be going to Medicare, Medicaid,
24 Social Security, and Federal Retirement, which has an
25 unfunded liability of $650 billion just in itself, Federal

1 Retirement.

2 That means in the year 2013, not too far away, there
3 will be nothing--nothing--for transportation, education,
4 defense, WIC, WIN, HeadStart, all the cherished things,
5 NEA, NEH, anything you might have on your list; those are
6 some on mine. That is where we are.

7 Let us get very clear on this. I have never been for
8 a tax cut for the rich or anyone else, so do not lay that
9 out as a great Republican caper. There are many of us that
10 do not embrace that; I do not. I do not see how we can get
11 there.

12 But I was surprised at the remarks of my friend, Jay
13 Rockefeller. He is my Ranking Member on the Veterans
14 Affairs Committee, a splendid gentleman. He is able,
15 bright, attuned to his constituents, but also a very tough
16 partisan, highly partisan, dramatically partisan. That
17 will not serve us well.

18 Let me say to my friend, I do not know any more about
19 the formula than you do, so let us not try to put some
20 partisan touch on that. In fact, the last one I saw had my
21 State getting cut 30 percent in Medicaid. So I would not
22 put anything too sinister out there with regard to that.

23 Furthermore, I understand from the committee that this
24 is the earliest that the mark has been released to the
25 members in the last decade. You all had it Friday; that is

1 when I first saw it. There has never been an opportunity
2 to have a more thorough review of an entire weekend before
3 we come to this part of the proceedings, so I think that
4 has to be on record.
5 Then I want to insert in the record what we have done
6 in this committee. We have had six hearings--five full
7 committee, one subcommittee--on Medicaid. We have had 10
8 full committee hearings on Medicare. We have even had
9 hearings on things that have not been touched in years
10 past, SSI, solvency of Social Security.
11 That was a well-attended hearing. It looked like
12 somebody had thrown an anti-personnel grenade into the
13 building. I looked around for my colleagues and their
14 staffs were trying to guide them away from the door. Do
15 not go in there, he is in there doing Social Security.
16 Well, take a look at that one.
17 As I hear these great laborers and great speeches of
18 courage, somebody should step up and ask us why Democrats
19 and Republicans have left off the table something that is
20 worth $360 billion--$360 billion--which is called Social
21 Security, which we are told will go broke in the year 2029.
22 When Pat Moynihan, Bob Dole, and company saved it in 1983,
23 it was supposed to go broke in the year 2063. Each year
24 they move it up four or five years, and we just sit here.
25 Now it is 2029.

1 I guess next year they will move it up to 2025. It
2 will begin to go broke in the year 2013, and you know it,
3 I know it, and the trustees know it, and three of the
4 trustees are members of this President's cabinet. This is
5 hard to even view as to what we are doing to ourselves.
6 Without mentioning the accursed word of Social Security
7 again, I urge you to look carefully at the work of Senator
8 Bob Kerrey and myself as we try to restore solvency to a
9 system. If you really want to do something, why do you not
10 means test the COLA on Social Security, because it is $7-16
11 billion a year, depending on that twisted little thing
12 called the CPI.
13 I do commend Pat Moynihan, and I am willing to go over
14 the cliff with you on that one. I thought that was a
15 given. That is an easy one. Over-estimation of the CPI
16 was from every witness we had, every single one.
17 Bob Kerrey and I thought that would be a snap, and
18 Danforth. No, no. That is raising the tax on senior
19 citizens. Well, play with that one, break the contract.
20 Anyway, that one we should be addressing, and I pledge my
21 earnest good efforts.
22 Is this radical? Sure, it is radical. But if you
23 really care about somebody, then you ought to start caring
24 about the people between 18 and 45, because the seniors are
25 not going to get dinged too hard on this one compared to

1 where they have been before.

2 But I will tell you, if we do not do something--and
3 even if we do this--is it not ironic that, and our good
4 Chairman says it with some energy and spirit, if we do this
5 without any delusion, Medicare will not go broke in the
6 year 2002, it will go broke in the year 2007. Every single
7 one of us here knows what the 30-year projections are on
8 these programs.

9 The President--and I mean this--in his first budget,
10 described intergenerational accounting, and I urge everyone
11 in America to read it. Get it out, read it. It was
12 powerful. And I thought, boy, I am ready to ride with Bill
13 Clinton on this one.

14 He described exactly what is going to happen to the
15 people of America in the years out. This year, somebody
16 political got to him and there was not a single word about
17 it, not a single word about what is going to happen to the
18 real lesser in society, who are people between 18 and 45.

19 If we really do care, then we will do something for
20 them. The something we are going to do, in all its high
21 drama, is going to be to allow all these programs to go up
22 6.4 percent out into eternity, I guess, and who can believe
23 how long that will last? How absurd.

24 Radical? Sure. But take a look at this Medicaid
25 reform. When they go to the States, they have to expend 85

1 percent of the funds for the most vulnerable persons in
2 society: family and pregnant women, disabled, elderly. It
3 cannot go below 85 percent, what it is now, by law, by what
4 we are proposing.
5 Well, you cannot get there from here by doing what we
6 are doing, and we are going to vote on a $5 trillion debt
7 limit, which will be the greatest badminton game in the
8 world's history, with the world of economics as the
9 shuttlecock.
10 How did we get here? Well, I have been here with four
11 Presidents: Carter, Reagan, Bush, Clinton. They did not
12 have a thing to do with it, not one of them. We did it.
13 We represented our constituents so well.
14 Everyone here has added a provincial touch to what they
15 have said. We have hauled it home like pack mules: roads,
16 commissions, HUD, every known federal program. That is
17 over. That is where we are.
18 That is very disturbing to a politician. It means you
19 might not get re-elected. Then you are caught in this
20 terrible thing that, if you start to look like a fiscal
21 conservative, you might get re-elected. So, that leaves
22 you kind of tattered. It is a heavy burden. But I sure
23 would not worry about the seniors on this one in any way.
24 I hope you will take another look at the bipartisan
25 commission work. Look at the 30-year projections. Know

1 that 30 of the 32 of us agreed on those projections. It is
2 really quite sad to believe that young people cannot seem
3 to get organized. They seem to be in some kind of vapor
4 lock.
5 I get interviewed by reporters who are usually between
6 30 and 40, and they come up and the original bias is, well,
7 what are you doing to the senior citizens? I say, do not
8 worry about them. They will be smuggling it out of here in
9 a sack.
10 [Laughter]
11 Senator Simpson. But I can tell you, you had better
12 worry about you because there will be nothing here when you
13 are 65, nothing. You know it, and I know it.
14 Get this figure. In Social Security, you get all years
15 back in the first six and a half years of the benefit
16 period. I was a self-employed lawyer in Cody, Wyoming and
17 I am 64 years old, and during my most productive years of
18 life never put in over $864 a year, and neither did any
19 other person on this continent.
20 I put in over $864 a year in those years when the lid
21 was $12,006, or $14,006, no matter what you made. No
22 matter what you made. When I got here, then of course it
23 was $2,000 a year, $3,000 a year, and I think now $4,000 a
24 year.
25 If I retire at 65--and many are praying that I will--I

1 will receive $1,140 a month. If I wait till I am 70, I
2 will get $1,500 a month. Now, that is what is out there.
3 We have to listen to this babble and this extraordinary
4 rhetoric about the old, the wretched, the poor, the
5 children, and the worst possible thing that can happen in
6 this country.
7 And what will happen is, in 20 years there will not be
8 any Medicare and the poor and downtrodden will be having to
9 pay their own. That will be the saddest thing that I can
10 possibly conjecture.
11 So, remember as you do this, the senior citizens of
12 America are probably the most fortunate people on earth.
13 I intend to means test Part B premiums, lady and gentlemen.
14 Part B is voluntary.
15 I am very disturbed to hear this continual babble
16 about, oh, you are going to raise the means test, the
17 premiums, on Part B, as if it were part of the contract.
18 It is not part of the contract, it was never part of the
19 contract. It is, in a sense, a welfare program because it
20 is an income transfer.
21 All of us and our predecessors sat here, and when we
22 passed it we said, you are going to pay 50 percent of the
23 premium and the government is going to pay 50 percent of
24 the premium.
25 But people who love to get re-elected came in here and

1 said, let us let the premium go down to 45 percent for
2 those poor, dear people. Voluntary, again, remember. Let
3 us get it down to 40 percent. That gets you re-elected.
4 That will really get you re-elected, and it did. Now it is
5 down to 31 percent.
6 So you have got Joe Gotrocks having 70 percent of his
7 premium paid by the people who swamp this building at
8 night. Got it? Get it. You know it, and I know it. You
9 are going to let that one get away?
10 Are you going to just ding the top three and four
11 percent of the rich in America? No, I am going to ding the
12 top 15 percent on a program which is totally voluntary, and
13 that is Part B, physician reimbursement.
14 Now, if we cannot get in and do some heavy lifting
15 here, then I hope that all of you with children and
16 grandchildren will at least have the courage to sit with
17 them in 30 years from now and say, well, we failed.
18 We were trying to let it go up only 6.4 percent a year,
19 but we all got thrown out on our fannies in a great
20 political revolution. So the Democrats who got re-elected
21 by throwing us out on that issue put it right back up to 12
22 percent and want to thank you. So the scenario, instead of
23 lasting 40 years, was capsuled down to 20. That is where
24 we are.
25 I am glad to be here. I am glad to work with anybody

1 on this committee on any part of these issues. But, by
2 God, I will not sit here and listen to much more babble
3 about what is going to happen to people over 60 when what
4 is going to happen to people between 18 and 50, or 45, is
5 disaster.
6 Thank you.
7 The Chairman. Senator Conrad.
8 Senator Conrad. Senator Simpson, do you have any
9 strong feelings?
10 Senator Simpson. I think I have had the passions wash
11 over me.
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF THE HONORABLE KENT CONRAD, A U.S.
2 SENATOR FROM NORTH DAKOTA
3
4 Senator Conrad. Well, there is much of what Senator
5 Simpson has said with which I can agree, and I think all
6 members can agree. There are things I frankly do not agree
7 with, especially the references to our colleague, Senator
8 Rockefeller, who I have never found to be an extreme
9 partisan, but somebody who does care deeply about who is
10 affected by the policies that we enact here, and I think
11 that is appropriate on both sides, that people feel
12 strongly about what we are doing.
13 I know our Chairman feels strongly. I want to add my
14 voice of welcome to Senator Roth. You are someone who has
15 felt passionately about the policies that come before the
16 Finance Committee, and I respect you for the strong
17 feelings that you have. And I certainly respect the
18 challenge that you face, because I do agree with Senator
19 Simpson that the country faces a fiscal crisis that demands
20 a response.
21 I strongly support the goal of a balanced budget. It
22 has been really one of the central items of focus in my
23 career in the United States Senate. I came here believing
24 deeply that the foremost challenge that we faced was to
25 balance the budget. And not just because balancing the

1 budget makes sense--it makes sense to spend what you take
2 in, and no more than that--but, more importantly, because
3 we face a demographic time bomb in this country, and that
4 demographic time bomb is the baby boom generation that is
5 going to double the number of people who are eligible for
6 Social Security and Medicare and these other programs, and
7 that is going to put this country in a very deep hole
8 unless we respond.
9 Beyond that, balancing our budget will strengthen our
10 economic future. It will mean more savings, which will
11 mean more investment, which will mean more economic growth.
12 That ought to be the goal of all of us.
13 Mr. Chairman, because I believe strongly in balancing
14 the budget I offered to my colleagues, when we had the
15 budget resolution on the floor, what I called a Fair Share
16 Balanced Budget Plan.
17 In that plan we balanced the budget by the year 2004,
18 but without counting Social Security surpluses. I might
19 add, both the Republican plan and the President's plan both
20 count Social Security surpluses to achieve balance.
21 I frankly do not regard that as balancing the budget at
22 all. To take retirement funds and put them in the pot and
23 call that balancing the budget, I think, is frankly
24 fraudulent. But when I look at the plan that is before us
25 I see dramatic differences.

1 The plan that I introduced balanced the budget by 2004,
2 again, without counting Social Security surpluses, but we
3 also did it without the kind of draconian cuts to Medicare
4 and Medicaid that we see in the Chairman's mark. Yes, we
5 had savings.
6 I hear people ask, where is the Democratic plan? Well,
7 you saw the Democratic plan: 39 of the 46 Democrats in the
8 United States voted for a budget plan that add $156 billion
9 of savings in Medicare over the life of that plan. It had
10 $125 billion of savings out of Medicaid. The fact is, we
11 recognize that there needs to be savings out of Medicare
12 and Medicaid, that the current levels of growth cannot be
13 sustained.
14 But when I look at the Republican plan that is before
15 us, I frankly must respond to you that I believe it is
16 extreme and that it is unfair. I might say to you, that is
17 not just the judgement of Kent Conrad.
18 I read, with great interest, the editorial of David
19 Broeder over the weekend that appeared in papers across the
20 country. David Broeder is not a partisan Democrat. I do
21 not even know what his party affiliation is, but he is a
22 respected national columnist.
23 Here is what he said. "The Republican revolution in
24 Congress is dropping its cloak of fairness faster than the
25 trees on Capitol Hill are shedding their leaves." He said,

1 "Last week, almost all pretense of equality in sharing the
2 burden of budget cutbacks disappeared." I think David
3 Broeder is exactly right.
4 When I look at the plan that is being advocated here
5 today, it is not fair, it is not balanced, it does not ask
6 for equal sacrifice from all Americans. It says to the
7 richest among us, you sit on the sidelines while we put the
8 middle class and the lower income people on the front lines
9 of fighting this battle. That is not fair.
10 Worse than that, it ushers the wealthiest among us to
11 be first in line to get additional tax relief, additional
12 tax benefits, additional tax preferences. That is not
13 fair, that is not balanced, that is not the way to address
14 a national emergency.
15 Mr. Broeder wrote, "While one House committee called
16 for the abolition of the Medicaid program of health care
17 for the aged, the indigent, and the disabled, another took
18 a whack out of what President Ronald Reagan and many others
19 have called the most effective and incentive-building
20 device for bolstering the income of the working poor."
21 Mr. Broeder wrote, "It would be pleasant to pretend
22 that these are oddities, but the accumulating evidence
23 points clearly to the conclusion that Republicans, who love
24 to accuse their opponents of practicing class warfare, are
25 really sticking it to the economically struggling families

1 of America."

2 He went on to point out that 20 years ago President
3 Gerald Ford signed into the law the first bill creating the
4 Earned Income Tax Credit, which basically gives low-income
5 workers modest help by refunding some or all of the taxes
6 they pay. It is a device, as he explains it, for getting
7 people off of welfare, and if you do not work you do not
8 get the benefit.

9 He also pointed out that President Reagan, in 1986,
10 called the Earned Income Tax Credit--this was Ronald
11 Reagan, this is not a partisan Democrat, this is a
12 Republican President of the United States--"the best anti-
13 poverty, the best pro-family, the best job creation measure
14 to come out of Congress." That is Ronald Reagan.

15 But last week, with minimum debate and on a party-line
16 vote, the House Ways and Means Committee decided to reduce
17 or eliminate Earned Income Tax Benefits for two-thirds of
18 the working poor who now get help.

19 Mr. Chairman, the version before us goes even further.
20 The House version cut $23 billion, the version before us
21 today cuts $40 billion. Mr. Broeder wrote, "Republicans
22 talk a lot about providing incentives. The rationale for
23 their plan to cut capital gains is that the top bracket
24 taxpayers, who receive most of the direct benefits, need
25 more incentives to save and invest.

1 But when it comes to the working poor," he wrote,
2 "the Republicans apparently decided that incentives are not
3 really that important. Their plan phases out Earned Income
4 Tax Credit benefits faster than current law and thereby
5 reduces the work incentives for over nine million
6 families." That is the House version he was writing about.
7 This version affects 17 million families, the plan that
8 we have before us in the Senate. It eliminates the Earned
9 Income Tax Credit entirely for childless workers. That is
10 the House plan and the Senate plan. And, he points out,
11 that knocks out four million people making between $350 to
12 $750 a month who otherwise would have received an average
13 benefit of $15 a month, and a maximum of $27 a month.
14 The Republicans say the Earned Income Tax Benefit
15 should go "only to those families with qualifying
16 children." Broeder wrote, "Ask yourself if you have ever
17 heard a Republican argue that capital gains tax cuts should
18 go "only to those families with qualifying children." I
19 have never heard them argue that.
20 "Republicans will tell you," Broeder continues, "that
21 some people have been fraudulently ripping off the Earned
22 Income Tax Credit." They have been, but the IRS has been
23 cracking down. The Ways and Means bill calls for added
24 compliance measures which are calculated to yield only
25 1/15th of the savings. The bill before us says the

1 additional compliance measure will account for only five
2 percent of the savings.
3 "The bulk of the $23 billion," Broeder writes, "will
4 come right out of low-income working families now eligible
5 for the program." Again, the savings in the Senate bill
6 are not $23 billion, as in the House bill, but $40 billion.
7 Broeder writes, "The Republicans say we are going to
8 give every family a $500 per child tax credit in our tax
9 plan." Broeder says, "That answer is the phoniest of all.
10 The Republicans," he writes, "do not make the credit
11 refundable, so one-third of the children in America would
12 not benefit at all because their family's income is too low
13 to be taxed.
14 On the other hand, because families with incomes of up
15 to $250,000 are eligible for the child credit, three
16 million families in America making over $100,000 each would
17 divvy up a pool of $11-12 billion."
18 Broeder concludes, "The Republicans' economics sure do
19 not jibe with their family values."
20 Now, Mr. Chairman, that is my conclusion as well. I do
21 not believe this plan is fair, that it is balanced. We
22 have got a national emergency. We ought to ask all
23 Americans to participate in solving this problem, not just
24 the middle class, not just the low-income working families.
25 We ought to ask everyone to be part of the solution.

1 I just cannot believe that it is fair or balanced to
2 give a $20,000 a year tax cut to people earning $350,000 a
3 year, and then say to people earning less than $28,000, you
4 pay $1,500 more.
5 Or to say to senior citizens, 70 percent of whom in my
6 State get by on less than $15,000 a year, you pay $2,500
7 more, while we give a $20,000 a year tax cut to those
8 making $350,000 a year.
9 Nor do I believe it is fair to ask students to pay
10 $3,100 more in student loans, while we are giving people
11 who earn over $350,000 a year a $20,000 tax break. That is
12 not fair, that is not balanced, that does not represent, I
13 believe, the priorities that we ought to adopt in this
14 committee.
15 Mr. Chairman, I believe we can do better. We can
16 balance the budget. We can do it in a way that is fair to
17 all Americans by asking even those who are the wealthiest
18 among us to contribute to the solution of this problem.
19 I thank the Chair.
20 The Chairman. Well, I would just point out that, in
21 respect to EITC, part of the problem has been waste and
22 fraud. It has averaged, over the several years it has been
23 in operation, 30-40 percent. What we are seeking to do
24 through the reforms is to ensure that these programs, these
25 benefits, go to those deserving under the original intent

1 of the program.

2 Senator Pressler?

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 OPENING STATEMENT OF THE HONORABLE LARRY PRESSLER, A U.S.
2 SENATOR FROM SOUTH DAKOTA
3
4 Senator Pressler. Thank you, Mr. Chairman, and may I
5 join in congratulating you upon assuming the Chairmanship
6 of our committee. I look forward to working closely with
7 you.
8 Let me say that this debate has an unfortunate partisan
9 tone. I have felt that partisan tone in my State in view
10 of some ads that have been run recently critical of me.
11 Those ads have stiffened my resolve to do what is right for
12 the American people.
13 One group of ads were run by a labor union under a
14 different name. I guess it is their foundation, or
15 whatever. The other ads are run by a group of hospital
16 people who might benefit if we spend more money, or think
17 they would.
18 In any event, the thrust of the ads is that Senator
19 Pressler does not care, Senator Pressler does not worry
20 about senior citizens, Medicare and Medicaid are going to
21 be taken away unless citizens call Senator Pressler's
22 office.
23 I come from a State, very frankly, where we have a
24 small Congressional delegation and I am the only
25 Republican. It is pretty clear that these are political

1 ads in nature, but they are also emotional ads.
2 I would say this. First of all, I had a father who
3 passed away with Alzheimer's disease, I have a mother who
4 is healthy, thank God, and 76 years of age. I am very
5 concerned about senior citizens and I resent the
6 implication that, just because I am participating in a
7 policy debate, that I am not worried about senior citizens
8 or that I do not care about senior citizens.
9 Even if we had a surplus in our Treasury, we should
10 still be able to analyze Social Security, Medicare, and
11 Medicaid. We should be able to talk about it, reinvent,
12 and improve.
13 If the expenditures are requiring a 10 or 11 percent
14 increase per year at a time when they should be requiring
15 about half that, good managers should be digging into it
16 and finding out how to better provide a service to our
17 people.
18 So I find that the tone of this debate, not only here
19 in this committee today, but also across the country, is
20 one of emotionalism and one of accusations and counter-
21 accusations.
22 But people who are elected to these offices have a
23 responsibility to make decisions, to administer programs,
24 and to be efficient. So I join in this effort, and my
25 resolve has been stiffened to do what is right by some of

1 what I consider very partisan behavior.

2 Now, Mr. Chairman, as all members of the committee
3 know, the President's own advisors have said that Medicare
4 and Medicaid will go bankrupt unless something is done.
5 Are we to let Medicare go out of existence, or are we to do
6 something about it? The plans that have been brought
7 forward are very reasonable. We are still increasing
8 spending, but not at the same rate. We are doing
9 management improvements throughout the system.

10 I have frequently said that even if we had a surplus in
11 our Treasury--which we do not have, we have a huge deficit
12 --we should still look at the management of this program
13 and find ways to improve it and better deliver services to
14 our people.

15 Now, in the case of my own State, I have worked closely
16 with Senators Grassley, Thomas, Baucus, and others in being
17 sure that the decisions that are made will be fair to
18 smaller cities and rural States.

19 I have joined in working on getting language regarding
20 incentives for primary care physicians practicing in rural
21 areas. Those, actually, under this bill, will be increased
22 from 10 to 20 percent, but we have not heard much about
23 that.

24 The Medicare-dependent hospital program will be
25 reinstituted, benefitting eight medicine-dependent

1 facilities in my State and elsewhere.

2 There are grants for telemedicine that will be made
3 available, thus improving access to health services for
4 rural and small city residents. Physician's assistants and
5 nurse practitioners will be directly reimbursed by Medicare
6 at a rate of 85 percent for outpatient settings. South
7 Dakota has 106 physician assistants, the majority
8 practicing in sparsely populated areas.

9 My State of South Dakota currently receives some of the
10 lowest AAPCC rates in the country. This bill addresses
11 that problem by attempting to equalize the differences
12 between the AAPCCs among counties nationwide. So my point
13 is, there has been a great deal of detailed work that has
14 gone into this bill.

15 I have a longer statement to place in the record, but
16 I think it is time that we address this program, a program
17 that will improve services to our senior citizens, a
18 program that will preserve Medicare and Medicaid, a program
19 that will keep our system solvent and sound and I am very
20 happy to join in the effort.

21 I thank you very much.

22 [The prepared statement of Senator Pressler appears in
23 the appendix.]

24 The Chairman. Well, I have to say, Senator Pressler,
25 nobody has been more aggressive in fighting for the rural

1 area than you, and I hope that the changes that have been
2 made answer the questions you have raised.
3 We are going to try to finish the opening statements
4 before we recess, or we are. Let me put it that way.
5 I will, next, call on my good friend, Bob Graham.
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF THE HONORABLE BOB GRAHAM, A U.S.
2 SENATOR FROM FLORIDA
3
4 Senator Graham. Thank you, Mr. Chairman. Mr.
5 Chairman, I wish to join with the others who commend you
6 and wish you well as you assume this new responsibility.
7 It has been a pleasure to have worked with you in the past
8 on a number of issues, and I look forward to doing so on
9 the issues before us today, and those that will come in the
10 future.
11 I would like to respond positively to the opening
12 comments that were made by my friend, the Senator from
13 South Dakota, relative to the need for bipartisanship. I
14 think one of the brightest periods in the history of this
15 institution in the 20th century occurred immediately after
16 World War II.
17 There was a recognition that there needed to be a
18 bipartisan spirit in order to frame a U.S. national
19 security and foreign policy that would respond to the
20 unprecedented consequences of the end of World War II and
21 the challenges imposed by an increasingly militaristic and
22 expansionist Soviet Union.
23 Out of that era, with people like Senator Vandenburg
24 and President Truman, a bipartisan foreign policy was
25 developed which stood this country in good stead for 50

1 years, and is significantly responsible for the fact that
2 today we do not face the threat that they did 50 years ago.
3 One of the principles behind that bipartisanship was a
4 recognition that the foreign policy which was being
5 developed was not just for an immediate period, but would
6 have to be sustained over changes in Congress, changes in
7 administration, changes in attitudes of American people, if
8 it were to have a chance of achieving its success of
9 containing, and eventually rolling back and then
10 contributing to the dissolution of Communism.
11 Similarly, I believe fundamental changes in domestic
12 policy require that spirit of bipartisanship if they are to
13 have the sustaining impact necessary in order to accomplish
14 their objective. Senator Simpson has talked about trend
15 lines that run, not just for our children, but for our
16 grandchildren. We must think in those links of time.
17 It is true that Medicare and Medicaid were Democratic
18 pieces of legislation, developed and passed by a Democratic
19 Congress with a Democratic President, but they do not
20 belong to any one political party.
21 Both parties must carry out their responsibility of
22 thoughtful oversight and recommendations for improvement of
23 these programs. So it is in that spirit of bipartisanship
24 that I raise some of the concerns that I will do.
25 I am concerned that the cuts of the magnitude proposed

1 here are not politically sustainable. These two programs
2 represent, Mr. Chairman, approximately 17 percent of total
3 federal spending; 17 percent of all the federal spending
4 this year will be in the Medicare and Medicaid program.
5 Yet we are asking these two programs to absorb
6 approximately 45 percent of all of the reductions in this
7 deficit reduction program. That is two and a half times
8 their level of contribution to federal spending that is
9 being asked in terms of their contribution to the reduction
10 of the federal deficit. I think that ratios of that
11 magnitude are unfair and unsustainable.
12 Second, I was very pleased at the comments that have
13 been made by at least two of the members of the Republican
14 Party, that they do not associate themselves with the
15 proposal for $245 billion of tax cuts, that they do not
16 have that as part of their agenda.
17 I am pleased with that because I think it offers the
18 opportunity to relook at the overall architecture of the
19 deficit reduction program. Those tax cuts represent about
20 20 percent of the totality of the budget resolution.
21 If we are going to consider withdrawing that amount
22 from the total cement of the budget resolution, that gives
23 us an opportunity to do some fundamentally different policy
24 steps in areas like Medicare and Medicaid that could
25 contribute to bringing us towards a bipartisan resolution.

1 I am concerned about the lack of specificity with which
2 we are facing this issue. We are now in the first of three
3 days of consideration, discussion, and mark-up of this
4 legislation.
5 For instance, in the area of Medicaid, our office has
6 not yet received the allocation formula so I cannot ask the
7 governor of my State, or other responsible officials, to
8 evaluate what the impact of this will be over the next
9 seven years on the efforts of our State to provide services
10 for some of the most vulnerable of our population.
11 I am concerned about the impact that this is going to
12 have on the States. We look at the chart, which is the
13 right chart of the two on the easels. There is a gap
14 between the line that is listed as Senate GOP revenues and
15 Senate GOP spending. And, according to the footnote at the
16 bottom, the Senate GOP revenues include State and local
17 extension and interest.
18 I do not know what the breakout of that is, but from
19 what I have seen, the proposal is to ask States and local
20 communities to pick up the share of the Medicare trust fund
21 for persons who are not currently covered, as well as
22 asking those persons to begin to contribute to the Medicare
23 trust fund. That may or may not be good policy, but there
24 is no question that it is going to have a financial impact
25 on the States.

1 Another example, in my State of Florida, the State pays
2 the Medicare premium for Part B and the other costs
3 associated with Part B for 306,000 people. Those are
4 persons who are Medicare beneficiaries who are also
5 indigent, and so they qualify for Medicaid; 52,000 of those
6 306,000 are in nursing homes in my State.
7 The effect of raising the premium, raising deductibles,
8 is going to be to transfer directly to the budget of the
9 State of Florida the cost of that for 306,000 people. That
10 is a very significant financial impact, a new unfunded
11 mandate, if we could use that phrase, on the State of
12 Florida. I think we need to know what the full
13 implications of this will be to States and to local
14 governments.
15 Next, I am concerned about the interrelationship of
16 decisions that we are making here to the major decision
17 that we made last week, which was welfare reform. The
18 reality is, welfare reform will not work unless we have
19 some basic supportive factors. One of those, is the Earned
20 Income Tax Credit.
21 I mentioned on the floor that one of the most extensive
22 welfare reform programs in the country is being conducted
23 in Pensacola, Florida. In the first few months of that
24 program, almost 10 percent of the AFDC beneficiaries in
25 Pensacola have secured employment.

1 The reality is that they secured employment at an
2 average hourly age of $5.40. They were getting the
3 equivalent of $7.00 an hour from the combination of AFDC,
4 food stamps, Medicaid, and subsidized child care. So what
5 is going to keep people working at $5.40 when they were
6 getting $7.00 in the value of the benefits that they
7 received while they were on welfare? Answer: the Earned
8 Income Tax Credit.
9 It was filling that gap and making it economically
10 possible, and making the desire of work realistic for a few
11 hundred people in Pensacola, and we hope, soon, for
12 millions of people across America. If we pull out that
13 factor, we are going to undercut the reality of our efforts
14 to achieve welfare reform.
15 We also need to maintain transitional Medicaid so that
16 that person earning $5.40, typically in a job that does not
17 provide for employer health care, will be able to have some
18 health care services for their children.
19 So these, Mr. Chairman, are some of the concerns that
20 I have. I would urge that we slow this process down. I do
21 not think we need to rush to judgment on issues that are as
22 important to this Congress, to the States and local
23 communities from which we come, and, most importantly, to
24 the people that we represent, especially now in light of
25 the fact that there seems to be some openings to consider

1 fundamental redeployment of the budget resolution that we
2 have adopted.
3 I would suggest that we provide for some additional
4 time to consider those alternatives, that we take what time
5 is available this week and in the weeks into October, until
6 we feel that we have arrived at that bipartisan consensus,
7 that we can report legislation to the full Senate.
8 Mr. Chairman, I have a full statement that I would
9 offer for the record. Thank you.
10 The Chairman. Without objection.
11 [The prepared statement of Senator Graham appears in
12 the appendix.]
13 The Chairman. Senator D'Amato?
14
15
16
17
18
19
20
21
22
23
24
25

1 OPENING STATEMENT OF THE HONORABLE ALFONSE D'AMATO, A U.S.
2 SENATOR FROM NEW YORK
3
4 Senator D'Amato. Thank you very much, Mr. Chairman.
5 I, too, would like to add my voice to those who have
6 congratulated you for the job that you have done under your
7 stewardship. This is not easy, to say the least. It is
8 tough, it is difficult. I want to thank you for attempting
9 to recognize some of the very difficult problems that we
10 have in our State.
11 Let me just share with you where we are at. In our
12 State system we have been gaming the Medicaid system for a
13 long time. We have got some unique needs, and problems as
14 well. But we do have the limousine, the stretch limousine,
15 of services, so to speak, with little regard to cost.
16 We have got the highest property tax rate and State tax
17 rate in the country. There is one exception, Alaska. Put
18 that aside. That is because of the unique provisions that
19 it has as it relates to oil and the revenues that it gets
20 from them. But, putting that aside, we are number one.
21 Let me just share with you an old figure, and it is
22 true today. One of our large, suburban counties, Suffolk
23 County, about 1.4 million people, every single penny that
24 they collect in property taxes, the county government, goes
25 to pay Medicaid, and then some. Then they have to add some

1 revenue.

2 I think the 1993 figure was $140 million that they
3 raised, and they, the county itself, contributed $144
4 million. And that just keeps going up, because we have a
5 system where local governments contribute 25 percent and
6 the State government 25 percent; that is our 50 percent
7 match. We get 50 percent, the Federal Government gives us
8 50 percent.

9 It has created nothing but absolute, total chaos. That
10 system has to be changed. It has been built over 20 years,
11 or longer. But it is confiscatory. People cannot live,
12 have to leave. Seniors certainly cannot live in our State.
13 By the way, that is true for all of our upstate countries,
14 and may even be worse, proportionately. So, it is not just
15 the big City of New York who is sucking the system dry.

16 I see that, and I have many of my colleagues come and
17 run. It is not just our teaching hospitals. So we have
18 the stretch limousine. We cannot stop the stretch
19 limousine and throw out all of the people who, for the most
20 part, are poor--many of them are poor--and replace it with
21 a little Volkswagen. We are not like the circus, that you
22 can then stuff in all of these people into the Volkswagen
23 after we empty it.

24 So, while we recognize the fact that we are going to
25 have to change our ways, that is, the State of New York, we

1 cannot do it overnight. We just cannot stop that stretch
2 limousine and push out all of the people who are being
3 served, all of the needs that are being met, and then throw
4 them into a little VW. It just does not happen; you are
5 going to leave a lot of people in the roadways.
6 I say this, because I recognize the incredibly
7 difficult job it is if we do not have sufficient resources
8 to make this transition. We have to cut down, but we need
9 some time in which to do it.
10 I want to thank the Chairman and his staff, who are
11 looking to try to ease this. They have done, again, with
12 no additional resources, an incredible job and we are on
13 our way. So, I just share that with you from our
14 perspective.
15 But then I have to ask a question, because this is
16 politics. This is the business of the people, and we are
17 kidding ourselves if we think there are not those that are
18 going to make--and they do--their points of view from their
19 perspective, from their party, someone with a little
20 sincerity of the world. I had two elderly women approach
21 me and say, you know, we are very upset, Senator; you are
22 cutting Medicare so you can give tax breaks to the wealthy.
23 So, that message is resonating out there.
24 But if we put aside the question of tax cuts, put it
25 aside, the system is flawed. It is in trouble. It is in

1 deep trouble and we have an obligation to do something to
2 fix the system.
3 Now, what is going to happen? We are going to try, as
4 imperfect as we are, to come up with a system. It will not
5 be a perfect system; it is not going to answer all the
6 needs of my State or all the States of my colleagues.
7 And it is going to be vetoed. I mean, is there one
8 person here who thinks that the President is going to sign,
9 basically, legislative initiatives that we put forward? Of
10 course he is not. Of course he is not. We are going to
11 hear more politicization of this thing?
12 If I had my druthers, which I do not, I would have said
13 to my distinguished colleagues, both in the House and the
14 Senate, do not link this business of tax cuts to fixing
15 this badly flawed system; put it aside. If you put the
16 question of whether you are going to cut taxes aside, you
17 have a system that is out of control. It will be bankrupt,
18 whether it is in six years or seven years. You have got to
19 do something.
20 Any doggone fool can say, let us not do anything. We
21 will just patch it and we will get past the next election.
22 If that is what we are about, then let us just keep up the
23 demagoguery, all of us. The President is going to veto
24 this. The best effort we make, it will be vetoed.
25 Now, therein lies, maybe, hope, because it seems to me

1 at some point in time the American people are saying very
2 clearly that they are not happy. They are not happy with
3 what we in office and what the parties represent. They
4 really want change, they really want us to do the business
5 of the people, and they don't see it taking place.
6 Maybe we could surprise them when we hit what will
7 appear to be a crash instead of us picking our best slogans
8 on the Republican side, and the Democrats picking their
9 best slogans, and throwing them back and forth. That is
10 not going to accomplish anything.
11 It seems to me--and I say this with deep affection and
12 great esteem--that the senior Democrat on this panel, the
13 senior Senator from the State of New York, has pointed to
14 something that might take some courage, but offers some
15 hope and opportunity to begin to resolve this dilemma,
16 where we can identify some resources, not so we can
17 continue spending as usual, let us understand that, but to
18 give, for example, States like New York and other States
19 the opportunity to begin to get their house in order, to
20 begin to bring the spending levels down. Then, also, to
21 begin to address and to solve the serious problem in real
22 terms, not just by saying, well, we are going to make the
23 cuts in the out years.
24 I see these budgets they put forth, whether it is over
25 seven years or 10 years, different people, and they say,

1 well, we are really going to cut the deficit in the 7th-
2 8th, or the 8th, 9th, and 10th year in the 10-year plan and
3 continue spending as usual. It is disingenuous. It is
4 nonsense. If you are not going to begin making those cuts
5 now, we are just kidding ourselves.
6 I want to commend Senator Moynihan, and I would hope
7 that people would circularize and read this, begin to
8 understand it. And there will be a hue and cry against
9 this proposal; oh, you are going to cut Social Security?
10 No. He is really saying that if we are paying more than we
11 should in cost of living adjustments, then let us fix the
12 formula. Maybe we could all come together.
13 By the way, just with the incisiveness of Pat Moynihan,
14 once again he points out, in some war room in the White
15 House basement someone is saying, "if we sign on to this we
16 will be accused of cutting Social Security and raising
17 taxes." Then he goes on to say, "and they will be right,"
18 meaning that is exactly what the battle cry is.
19 But, of course, that is wrong. That is really wrong,
20 but the battle cry will go up. Then it might take all of
21 us, working in a bipartisan effort, to educate. We could
22 do that. Would that not be astounding? Would that not be
23 astounding?
24 We talk about bipartisanship, that is the kind of thing
25 that is built on some facts, that we are spending, we are

1 out of control, we are spending more than we can. How do
2 we begin to deal with this phenomena?
3 I might just say one other thing. I have to tell you
4 something. We should be ashamed of ourselves. We have
5 some fellow who is retired and has a retirement income of
6 $75,000, $80,000, $100,000, and we are subsidizing--and
7 Senator Simpson pointed it out--the custodians, the working
8 class people, the middle class families, trying to educate
9 their children, and they are helping to pay for that
10 person's health insurance when he or she can afford to pay
11 the full premium and they are only paying 31 percent. It
12 is nonsense.
13 Affluent people should pay their own. We should not be
14 standing for protecting the privileged class. If you have
15 the means to pay for it, you should pay for it. Do not let
16 other people do it. That is going to call for a little bit
17 of courage here, and similarly, as it relates to Social
18 Security.
19 So I hope we do not get too exercised as it relates to
20 the detail of this particular plan, because it is going to
21 be vetoed. I mean, it absolutely will be vetoed. The
22 President is going to continue to say, the Republicans want
23 to take from the senior citizens and those who cannot
24 afford it, and I tell you, no. I saw that pen. He was
25 raising that pen. He did that already. And I will veto

1 it. He will. He will.

2 But where are we then? I would hope that we could come
3 back to something that Senator Moynihan has suggested, come
4 back to the basis of trying to fix this. Nobody is looking
5 to injure seniors, nobody is looking at take-away, but to
6 improve this system so that we do do the business of our
7 people.

8 Again, Mr. Chairman, I want to thank you. To Senator
9 Moynihan, I want to commend you and thank you for the
10 courage that you have displayed in putting forth the issue
11 and putting it forth in just only the way that you could,
12 so cogently. By the way, it says the CPI is an easy fix.
13 Now, I disagree with you there, now.

14 Senator Moynihan. That was The Washington Post,
15 anyway.

16 Senator D'Amato. All right. I commend you for
17 putting forth something that we should be undertaking, and
18 we should be doing it now.

19 Senator Moynihan. I thank my esteemed colleague.

20 The Chairman. Thank you, Al.

21 Senator Moseley-Braun.

22

23

24

25

1 OPENING STATEMENT OF THE HONORABLE CAROL MOSELEY-BRAUN, A
2 U.S. SENATOR FROM ILLINOIS
3
4 Senator Moseley-Braun. Thank you very much, Mr.
5 Chairman. It has been said already, but I also want to add
6 my congratulations to you for your Chairmanship and your
7 stewardship of this committee.
8 Mr. Chairman, I am the next-to-last person to speak and
9 I have had a chance now to listen to all of the debate,
10 partisan or otherwise. I could not help but sit here and
11 think that one of the reasons that it sounds so partisan,
12 I think, is that it is difficult to take this mark all that
13 seriously since everybody in this room and everybody who is
14 listening knows that it, very patently and obviously, is an
15 exercise in Robin Hood in reverse.
16 This proposal is so extreme. It has been called
17 radical, it has been called extreme, but the major reason
18 for that is so they can give a tax cut to high-income
19 taxpayers.
20 Certainly we do need to have reform. I served on the
21 bipartisan commission with Senator Simpson. We had
22 occasion to look at the budget trends. There is no
23 question but that we need to achieve budget balance, there
24 is no question but that we need to stamp out fraud, waste
25 and abuse wherever we can find it.

1 In the EITC, to the extent that that has been raised as
2 an issue, it ought to be addressed. There is also no
3 question that high income tax payers could contribute more
4 to get health care inflation under control. But certainly,
5 Mr. Chairman, it is no secret to anybody that strengthening
6 Medicare would take about $89 billion, not the $270 billion
7 that is proposed in this mark.
8 The whole point of the extreme cuts in Medicare and
9 Medicaid, $270 billion in Medicaid, $182 in Medicaid, the
10 $32 billion in EITC, is so that we can come up with the
11 money to pay for a $245 billion tax cut.
12 That, Mr. Chairman, in my opinion, and I think in any
13 rational analysis, is not the kind of sacrifice sharing, is
14 not the kind of fairness, certainly is not the kind of
15 reform that I think this committee ought to engage in.
16 Mr. Chairman, more than 50 percent of the sacrifice
17 required by this mark is from low- and moderate-income
18 people, and that is just not fair, and to this Senator is
19 not acceptable.
20 The most egregious part of this mark is what it does to
21 the Earned Income Tax Credit, and I know we will hear from
22 the last Senator on that point, after what was done to
23 welfare. After that, doing this to the EITC, the Earned
24 Income Tax Credit, is no less than an outright assault on
25 poor people.

1 These so called reforms represent a tax hike, a tax
2 increase, averaging some $281 a year for taxpayers who earn
3 less than $20,000 a year. Understand, the EITC, that is
4 earned income tax credit. We are talking about working
5 people, we are talking about people for whom we are
6 encouraging work over welfare, encouraging self-
7 sufficiency, over-dependency.
8 Yet, what this committee mark does is, for each dollar
9 of additional earned income, a low-income family of four
10 would lose almost 20 cents in reduced EITC refunds, three
11 to four cents in State income tax benefits, and effectively
12 their tax rate would be raised, in some cases, an average
13 of 55-68 percent. It kicks those who do not have children
14 at all off the Earned Income Tax Credit refund proposal
15 altogether.
16 I would point out, by the way, on the point of tax
17 fraud, waste and abuse in the EITC, it has been admitted in
18 hearings that this committee has had that some 35-45
19 percent of so called fraud, waste and abuse was error,
20 admitted error, by the Internal Revenue Service.
21 So you cannot really say that that is just a matter of
22 poor people taking advantage of something, this is a case
23 in which the bureaucrats really have not worked it out
24 entirely and there have been errors. Should we fix EITC?
25 Absolutely. Should we do it to the point this mark calls

1 for? Absolutely not.

2 Mr. Chairman, in Illinois this mark would mean that
3 some 746,000 taxpayers, working people who make less than
4 $20,000 a year, would pay, by the year 2002, $642 in
5 additional taxes; some 307,000 families with two or more
6 children will pay $941 more in taxes by the year 2002. So
7 what we have here is a tax hike on the working poor, and it
8 seems to me that, coupled with the tax cut for well-off
9 taxpayers, that is just unconscionable.

10 Mr. Chairman, I would go further to say that the direct
11 hits on the poor and working class Americans in this bill,
12 as bad as it is, pales in comparison with the indirect
13 impacts.

14 Part A Medicare changes, $655 billion will have a
15 quadruple hit on academic teaching hospitals, on public
16 hospitals, and on private, rural, and inner city hospitals.
17 All of these institutions are being called on by this mark
18 to absorb multiple cuts, cuts to inpatient hospital
19 reimbursement, disproportionate share, capital programs,
20 and graduate medical education.

21 It, in effect, Mr. Chairman, calls on us to gamble,
22 again, with the health safety net, gambling with a safety
23 net that affects seniors' abilities to get health care and
24 the working poor's ability to struggle out of poverty, all,
25 again, to squirrel away $245 billion for a tax cut.

1 I am delighted, frankly, to have heard some of my
2 colleagues now, three members, who say that they are not as
3 wedded to this tax cut business. One Senator suggested,
4 well, let us just forget about the tax cut altogether and
5 talk about this in the abstract without it. I would love
6 to do that, but, quite frankly, the fact that the tax cut
7 is here really just makes whatever errors there may be in
8 this mark even that much more egregious.
9 One of my colleagues talked about Topsy Jusgrowen. I
10 started to point out to him at the time, the good news is,
11 the Topsy Jusgrowen survived and she was still alive. That
12 is more than what can be said of the health care insurance
13 protections that are provided in this mark.
14 In my State of Illinois alone, this 30 percent cut,
15 $9.3 billion in Medicare, $6 billion in Medicaid, over
16 seven years, will affect and impact a State that is already
17 below the National average of health care support for
18 children, the elderly, and the poor. It is a State already
19 above the National average in infant mortality. The number
20 of uninsured children is calculated to go up from 9.5
21 million children to 19 million children.
22 The providers, including hospitals and nursing homes,
23 already in my State have suffered a delay of over $1
24 billion in payments nearly six months to a year because the
25 State cannot afford to pay them. Those provider payments

1 will be delayed further under this mark.

2 The safety net for Medicare that Medicaid provides--and

3 I was delighted that the Senator from Florida referenced

4 this point--for low-income seniors who cannot pay the

5 deductibles, Medicaid provides a safety net for them with

6 regard to the Medicare program.

7 In my State alone, you are talking about 128,000 who

8 are under the poverty line. That safety net will be wiped

9 out altogether by this mark. Remember, Mr. Chairman, 75

10 percent of Medicare beneficiaries--Medicare beneficiaries--

11 have incomes of $25,000 or less; 35 percent of Medicare

12 beneficiaries have incomes of under $10,000 a year.

13 As to those 35 percent, those people, there is a

14 possibility in the Medicaid changes that they will be

15 deprived of whatever access, the key, if you will, the

16 entry, to the health care system altogether.

17 So, Mr. Chairman, the cuts that are represented in this

18 mark, again, the cost shift, it seems to me is a cost shift

19 from the balance sheet that we are looking at, that the

20 numbers crunchers on the federal level come up with, to the

21 personal balance sheet of working Americans and people who

22 are least able to pay. That, it seems to me, is the fatal

23 flaw of this plan.

24 The Chairman has asked the question, well, what is your

25 plan? Well, I would point out that you have got the

1 majority and you have the votes. But the fact is, the
2 sincerity of this approach is called into question by this
3 tax cut.
4 I think there are many of us who believe that reform is
5 necessary if we are going to achieve a balanced budget. A
6 reform, overall, is necessary, but the tax cuts suggest
7 something else altogether.
8 This tax cut and this plan, as put together, will
9 represent a windfall for the managed care operations, a
10 windfall for high-income taxpayers, and frankly a free for
11 all for everybody else.
12 It seems to me, Mr. Chairman, that if we wanted to do
13 so based on the suggestion of three of the colleagues on
14 the other side of the aisle, then we should take that $245
15 billion and put it back in the Medicare trust fund.
16 If you are not going to use it for deficit reduction,
17 then let us put it back into the trust fund and ameliorate
18 some of the draconian cuts that this represents in terms of
19 the health care safety net.
20 Finally, Mr. Chairman, again--and I am trying to be as
21 even-handed as I can; this is not a partisan speech, this
22 is a sincere policy point of view and I think I referenced
23 that for you--I want to refer also to the David Broeder
24 article, and frankly I'd like to have it admitted to the
25 record in this debate today. The title of the article,

1 which Senator Conrad did not mention, was "So Much For
2 Fairness."
3 Well, fairness is what we have to be about in the final
4 analysis in this committee. It seems to me that, as a
5 National community, we are called on to do better than this
6 mark allows us to do.
7 We are called on to balance the interests and concerns
8 as we balance the budget. We are not just here to crunch
9 numbers, we are here to be fair to the American people.
10 That is the job that we were elected to do, whether
11 Democrat or Republican.
12 Mr. Chairman, I therefore hope that, without waiting on
13 whether or not the President's going to veto this bill or
14 not, what we crank out of this Finance Committee does a
15 better job by the totality of our interests as Americans,
16 because in the final analysis we are all in this together.
17 If we rend asunder the health care safety net and shift
18 the burden to low-income working people, as this mark
19 suggests that we do, we will have not called on Americans
20 to share in the sacrifice to reach a balanced budget, we
21 will have tilted the balance altogether and in so doing
22 will have set ourselves up for a horrendous fall.
23 Thank you, Mr. Chairman.
24 The Chairman. Well, just let me repeat something I
25 said earlier. A number of my colleagues on the Democratic

1 side have talked about tax cuts. I think it is worthwhile
2 reading once again what The Washington Post had to say
3 about the attack on tax cuts in the editorial on September
4 25th. The Washington Post said, "The Democrats have
5 fabricated the Medicare tax cut connection because it is
6 useful politically. It allows them to attack and to duck
7 responsibility both at the same time." It concludes that,
8 "we think it is wrong."
9 My question is, if you do not like our plan to save
10 Medicare and Medicaid, what is yours? That fact is, there
11 is general agreement, a consensus, that both of these
12 programs are in difficulty and we have to address that.
13 What we are seeking to address in the problem of these
14 programs is the slowing down of the growth.
15 My friends on the other side keep talking about
16 spending cuts. We are not talking about spending cuts in
17 these programs, we are talking about slowing down the rate
18 of growth. That is important to understand.
19 It is also important to understand that the providers,
20 while we are putting restraints on what they will be
21 reimbursed, at the same time will continue to enjoy an
22 increase in revenue for their profession roughly 4-8
23 percent. But the important fact we face is, if nothing
24 happens, these programs are in difficulty. We cannot
25 permit that to happen.

1 Senator Nickles. Mr. Chairman?

2 The Chairman. Yes, sir. The Senator from Oklahoma.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 OPENING STATEMENT OF THE HONORABLE DON NICKLES, A U.S.
2 SENATOR FROM OKLAHOMA
3
4 Senator Nickles. Mr. Chairman, I will be very brief,
5 since I have a couple of commitments at which I need to be.
6 I compliment you and Senator Moynihan for your patience, as
7 well. I think this has been educational, maybe some kind
8 of idea to find out where people are coming from.
9 I would also like to compliment you. I have been in
10 the Senate for 15 years, and you have been Chairman of this
11 committee for one week, and for the first time we are
12 actually talking about trying to contain the growth of
13 entitlements.
14 We did not do it, really, under the Reagan
15 Administration, we did not do it under the Bush
16 Administration, and we certainly did not do it under the
17 first two years of the Clinton Administration, but now we
18 are.
19 We are talking about it, we are trying to do it. A lot
20 of people are objecting. A lot of people are saying, we
21 cannot do it, we should not do it. A lot of people are
22 calling things cuts, when actually we are trying to slow
23 the growth of programs.
24 I do not know how many times we have heard, well, we
25 are cutting Medicare $270 billion. In Medicare this year

1 we are spending $178 billion; in seven years we are going
2 to be spending over $286 billion. That is an increase of
3 $108 billion, but everybody is calling it a cut. Medicare
4 is going to grow over six percent per year.
5 President Clinton's revised budget had Medicare growing
6 at 7.1 percent. Those are OMB's numbers. He used OMB as
7 a base instead of CBO, for whatever reasons. Maybe it made
8 his numbers look better. But this budget says that
9 Medicare should grow at 6.4 percent.
10 President Clinton's revised budget says it should grow
11 at 7.1 percent. President Clinton did not submit how he
12 would get to those numbers. We have now done so, and
13 certainly it is subject to criticism and ideas. Maybe it
14 should be done differently or better, but at least we do
15 have a plan. We need to make some changes. This is the
16 first time that we have ever really talked about curtailing
17 entitlements.
18 I want to compliment my colleague from New York and
19 tell him that I was working on an op-ed piece saying that
20 we should address CPI. This should be done irregardless of
21 what the budget situation is.
22 And we should be making a lot of these Medicare
23 changes, Medicaid changes, and EITC changes, regardless of
24 what the budget situation is, because changes are called
25 for. We should give Medicare beneficiaries options. We

1 should allow them different choices.

2 We should stop subsidizing very wealthy people. We
3 should not be asking people making $20,000 to be
4 subsidizing people who make over $150,000, to pay part of
5 their Part B premiums, as we do today. We should be making
6 changes. We should use accurate CPI adjustments, or cost
7 of living adjustments. We should use that, even if we had
8 a surplus.

9 We should be making an accurate reflection of CPI.
10 Some people said, well, wait a minute. Are we not going to
11 take some heat for it? I do not find that a particularly
12 difficult thing to explain. We should use accurate
13 figures, so let us do it.

14 I do not think we should do that as a substitution for
15 making some of the policy changes that need to be made. We
16 should be giving Medicare beneficiaries options, choices.
17 We should cap or curb the growth of Medicaid.

18 The last four years of Medicaid, the growth was 28, 29,
19 13, and eight percent. That is not sustainable. We should
20 cap or reduce the rate of growth on the Earned Income Tax
21 Credit, something that I think is grossly misnamed. This
22 chart shows the spending level: it has just exploded.

23 In 1990, we were spending, I think, $6.9 billion on
24 EITC, and now the cost is over $23 billion. Now, that is
25 an explosion. That is not sustainable. We have to reduce

1 it. Then when you have a GAO report that says 20, 30, 40
2 percent of the program is either done in error or through
3 fraud or abuse, it is all the more reason why it needs to
4 be reformed, and that is what we are trying to do.
5 Some of our colleagues have made some comments that I
6 just have to allude to. First, I would make another
7 comment on Medicare. People have said, well, we have
8 reformed Medicare, we have saved Medicare, and the trustees
9 have come in time and time again and have said, hey, the
10 fund has gone broke, we need to do something.
11 What has Congress done? Congress has increased taxes,
12 payroll taxes, with big payroll tax increases. In 1978,
13 the payroll tax for Medicare was one percent, on a base of
14 $17,700 a maximum payment. For employer and employee
15 combined, it was $177. That is just more than quadrupled.
16 Today the tax is 2.9 percent, with no limit. In 1993,
17 it was 2.9 percent on $135,000. That meant, if somebody
18 had that level of income, they paid $3,915 on Medicare. So
19 we have had big tax increases.
20 Then we took the cap off, so now it is 2.9 percent on
21 all wages, no limit. Yet the fund is still going broke,
22 according to the trustees. We have raised taxes a bunch.
23 But tax increases are not the solution, so we have to
24 reform the system.
25 The private sector, which I used to be part of and used

1 to be involved in purchasing health care, we offered
2 employees different options, including self-insurance and
3 catastrophic. The private sector is doing a lot of things
4 like that, but Medicare is not. So, we need to reform it.
5 I think we should reform it, again, whether we have a
6 budget problem or not. Certainly, we should do so.
7 Earned Income Tax Credit. I will make a few comments,
8 because it was alluded to. Some people called this a
9 savage attack on the working poor. This was paying for a
10 tax cut for the wealthy, a tax hike on the working poor.
11 I wrote down some of these comments. I just totally
12 disagree.
13 The Earned Income Tax Credit, Mr. Chairman, as you
14 know, over 80 percent is a direct cash payment. A direct
15 cash payment, an outlay, not a tax refund, not a tax
16 reduction, a cash payment, which now exceeds the AFDC cash
17 payments, and over the next several years would exceed it
18 by billions of dollars.
19 I think we show the reforms that we have made. Those
20 reforms are common sense. I would mention to my friend
21 from Illinois, she talked about two or more children and
22 said, well, this is a tax increase on two or more children.
23 Let me just give you a couple of facts. The maximum
24 tax credit allowed for a family with two or more children
25 in 1990 was $953. Today, the maximum tax credit under

1 Earned Income Tax Credit is $3,110. That is a big
2 increase. That is three times as much in 1995 as it was in
3 1990.
4 Current law says, another seven years it will be
5 $4,300. We reform it, but the maximum payments goes from
6 $3,100 in 1995 to $3,800. So, in other words, the maximum
7 credit allowable under our plan still increases. We allow
8 increases.
9 Granted, $3,800 is less than 43, but I might again
10 remind my colleague, these are cash payments. They are not
11 a reduction in somebody's taxes, they are cash payments.
12 Those are checks that we are writing to individuals. So
13 right now the maximum credit went from $950 to over $3,000;
14 under our proposal, it rises to $3,800. It continues to
15 rise, it just rises a lot slower.
16 Now, we do make some other reforms. We say that
17 illegal aliens will not be able to receive the credit, we
18 say the credit would not be available for individuals
19 without children. That is the way the program was
20 designed. I might mention, we have AFDC. That is Aid for
21 Families with Dependent Children. Welfare programs are set
22 up like that.
23 We also say, on eligibility, who is eligible for this.
24 We should basically declare almost all income. Right now,
25 you can have business losses. An individual could have one

1 or two in their family earn, let us say, $40,000 or
2 $50,000, but they can have business losses that would
3 basically offset most all that income, and still qualify
4 for EITC.
5 Senator Moseley-Braun. Will the Senator yield?
6 Senator Nickles. Not for the moment. I might in a
7 moment.
8 They can have net losses from rents and royalties, they
9 can have net capital losses. We are saying, wait a minute;
10 you should not be able to do that. You should basically
11 count all income.
12 Right now, the income levels for the Earned Income Tax
13 Credit, families now qualify if they have two or more
14 children up to levels of $26,000. That figure under
15 current law says that people would qualify if they have
16 incomes up to $34,600. We reduced that somewhat.
17 We say that current law would still say the same for
18 income with two families, but the income would be moderated
19 to where they would only qualify at $30,000. It still
20 increases, present law. Families with two or more children
21 qualify at $26,000, and we allow that to go up to $30,000.
22 Present law says up to $34,000. So, we moderate it
23 somewhat.
24 But, my land, if the Federal Government is writing
25 checks--again, keep in mind, 80 percent of this program is

1 a net outlay, Uncle Sam writing checks, it is not a tax
2 credit, it is a check, a cash payment made to individuals--
3 we should moderate the growth because this growth rate is
4 not sustainable.
5 If you look at the chart on the right, you can see
6 under the Senate reforms the total cost of the program
7 continues to increase. It does not increase as much as
8 under current law. We keep the percentage, I will tell my
9 colleague from New York, at 36 percent.
10 Current law would say it should go to 40 percent. That
11 means for every $1,000, Uncle Sam would be writing a check
12 for $400. We say, no, it should stay at $360, because that
13 is very expensive.
14 This program, again, if you keep in mind, look at this
15 low-income family of $15,000 or something, Uncle Sam is
16 writing a check for $3,100. Under our program, that check
17 will rise. It will rise, actually, to $3,888, almost
18 $3,900. That is not as much as $4,300, but we just think
19 the growth of the program has to be moderated.
20 It still grows under our proposal. I notice my friends
21 and colleagues, when they quote Ronald Reagan, saying this
22 is a great program, the program at that time cost $1
23 billion and the program was expanded. Still, it was a $2-3
24 billion program. It only cost $2 billion in 1986; today it
25 costs $23.7 billion. Wow. There is no other program in

1 government that has exploded in cost like the so called
2 Earned Income Tax Credit.
3 Again, the cash payment program, the GAO says they have
4 error rates of 30 or 40 percent, an unbelievable amount of
5 fraud, a lot of people have really abused the system. It
6 needs to be reformed. If we are ever going to balance the
7 budget we are going to have to tackle entitlements.
8 Why did I have an interest on taking on EITC? Because
9 I do charts on a lot of things and I noticed no program was
10 growing as fast as this program. So, we are looking.
11 This committee is showing some courage because, for the
12 first time, we are looking at programs like Medicare, like
13 Medicaid, like Earned Income Tax Credit, like some of the
14 welfare programs, that really have grown out of control,
15 because Congress set up laws and made people entitled to
16 them.
17 Now, for the first time really in history, we are
18 saying we should curtail the growth of the so called
19 entitlement programs. We will never, ever balance the
20 budget unless we do so. To my colleagues that are saying,
21 well, wait a minute, are you not doing this in order to pay
22 for a tax cut for your rich friends? I just totally
23 disagree.
24 Most all of these things should be done whether or not
25 we have a tax cut or not. Most of these things should be

1 done whether or not we are in balance or not. You should
2 not have a program where 40 or 50 percent of the District
3 of Columbia is entitled to a cash payment from Uncle Sam.
4 So I hope that we will make these reforms. I hope that
5 we will also do additional, and do some of the reforms that
6 need to be made for an accurate reflection of the cost of
7 living.
8 Finally, I will just mention, when people are talking
9 about tax cuts, this Senator is going to work very hard to
10 make sure that we make these reforms, and then the tax
11 cuts, the bulk of the money--60 or 70 percent, or two-
12 thirds of the tax cuts--are going to be family-friendly and
13 they are going to go to families with children. I hope
14 that is the case.
15 We have introduced legislation that I hope will be part
16 of the final package that will have a tax credit of $500
17 per child, because we do believe in families and we do
18 think that families should be able to spend the money
19 better than the Federal Government. So, we want to reduce
20 the rate of growth of spending, but we also want families
21 to be able to keep more of their hard-earned dollars. So,
22 I hope that we will stay to the facts.
23 I think if we stay to the facts, Mr. Chairman, we will
24 be in good shape. I look forward to working with other
25 members of this committee for a successful resolution of

1 this reconciliation bill, one that the President can, and
2 will, sign.
3 Senator Moseley-Braun. Mr. Chairman.
4 The Chairman. Yes.
5 Senator Moseley-Braun. Since the Senator from
6 Oklahoma would not yield, I would like to talk about the
7 facts for a minute on EITC. Quite frankly, it is stunning
8 to me that, with all of the words you used, it did not make
9 a whole lot of sense to me. That is because I think that
10 what you did was confuse facts and numbers in a way that it
11 was not comprehensible.
12 In the first place, the EITC is not AFDC. It did not
13 conceptually rely on an individual having children,
14 conceptually, the EITC related to someone who was working,
15 but was poor. Whether that person had children or not
16 should not have been, or was not considered to be, a
17 determinant of eligibility.
18 What this mark suggests is that you have to have
19 children, which makes EITC effectively a form of what was
20 considered to be Aid to Families with Dependent Children.
21 That, it seems to me, is a philosophical and practical
22 shift in the program's operation that will have dramatic
23 effect.
24 Again, speaking to the facts, it means that all of the
25 individuals who right now are single people, just poor

1 people who are working, will not be eligible for the EITC.
2 That raises about $6 million, and it affects hundreds of
3 thousands of people.
4 So, number one, in terms of the conceptual facts about
5 EITC, is it not an AFDC program, it is not dependent on
6 dependent children, it was defined only in terms of
7 poverty. That is the first point.
8 The second point ----
9 Senator Nickles. Mr. Chairman, am I on my time?
10 Senator Moseley-Braun. No. I asked the Chairman for
11 time, so this is my time.
12 The Chairman. Could I ask that you keep your remarks
13 short, because we are going to try to adjourn in just a few
14 minutes in order to do some housekeeping.
15 Senator Moseley-Braun. Yes, sir. I will be brief.
16 The second point is, by virtue of the proposed changes
17 in the definition of qualifying income, working women who
18 have children will be doubly hit because child support is
19 taken out, or is added as one of the things that
20 disqualifies eligibility for EITC.
21 So somebody who makes $20,000 a year and has child care
22 costs of $200 a month child care cost and then gets maybe
23 $250 a month in child support, that person would have her
24 EITC reduced by $8,000 annually.
25 Senator Nickles. They do not get that much.

1 Senator Moseley-Braun. They will by the end of the
2 projected period that you have on your chart there. So
3 working women with children will be doubly hit because of
4 the changes in the EITC.
5 The Chairman. Could I just interrupt? The hour is
6 growing very late and there is going to be ample
7 opportunity to discuss these matters in the future.
8 Senator Moseley-Braun. Yes, sir.
9 The Chairman. I do not want to cut you off.
10 Senator Moseley-Braun. Let me just say, Mr. Chairman,
11 it is all right. I will allow myself to be cut off this
12 time voluntarily. I thank you for your graciousness in
13 allowing me some response, but I just had to respond, Mr.
14 Chairman. I would like, frankly, to respond in detail to
15 the statements my colleague made.
16 The Chairman. I would just make one comment, and that
17 is that this program was limited to families with children
18 up to two years ago. That is an innovation that came about
19 through this administration.
20 Senator Moynihan. Through this Chairman.
21 The Chairman. But, in any event, let me say that we
22 do have a modification in the Chairman's mark which
23 contains the following items: changes in policies regarding
24 inflation updates for health care providers; clarification
25 of the formula for computing the Medicare payment rates for

1 Medicare choice plans; and several technical amendments.
2 As we walk through those, they will be spelled out in more
3 detail.
4 Senator Moynihan. And we have your summary financing
5 provisions.
6 The Chairman. Yes, that is correct.
7 I do not know if you, Lindy, want to make any opening
8 remarks at this stage, but we intend to close about 12:45.
9 There will be a vote at 2:20 on the Senate floor, so it is
10 our intent for the committee to reconvene here at 3:00.
11 Ms. Paull. Yes, Mr. Chairman. Let me just go over a
12 broad overview of what we are working on today and what we
13 will be working off of for this afternoon when we come back
14 to do the official walk-through.
15 This is the spending part of the budget resolution,
16 instructions to the Finance Committee. The Finance
17 Committee had instructions to restrain spending to the tune
18 of $530.4 billion over the next seven years.
19 The total that was called for in the budget resolution
20 was $632 billion over seven years, so a significant share
21 of the work, over 80 percent of the work, is in this
22 committee.
23 That is because, as has been pointed out earlier today,
24 that this committee has most of the entitlement programs
25 under its jurisdiction and a significant number of

1 entitlement programs that have been growing at a rapid pace
2 for the last 5 to 10 years and are estimated to continue to
3 grow at a rapid pace in the future.
4 The challenge of the budget resolution for this
5 committee was to restrain the spending in the Medicare
6 program to roughly 6.3 percent growth in the future, and
7 the Medicaid program, 4.9 percent in the future.
8 What you have before you is basically three things at
9 this point. One, the original mark that was released on
10 Friday that had been sent to every member's office. We
11 have just put before you the modification to the mark that
12 the Chairman just spoke of.
13 Included in this modification also are three additional
14 proposals that will make up a shortfall out of the welfare
15 bill from the Senate floor. Then the last item that you
16 have before you is a series of charts, one of which is
17 missing and we hope we will have it for you this afternoon.
18 Senator Moynihan. That is the one for Medicaid.
19 Ms. Paull. That is the Medicaid chart.
20 Senator Moynihan. A table.
21 Ms. Paull. Table. They are named charts, but you are
22 right, they look more like tables.
23 The first one summarizes the Chairman's mark package,
24 which we will go through in this order after the break: the
25 Medicare proposals, reaching a CBO estimate of $270.3

1 billion over the seven years. Medicaid reforms. Again,
2 the target was $182 billion. We have not got the precise
3 number. It could vary, plus or minus 0.5 billion here when
4 we get it back from CBO.

5 On the Earned Income Tax Credit, these are the outlay
6 savings only. You will see the estimate by the Joint
7 Committee on Taxation. That is included, and numbered
8 Chart 4. It also includes some tax savings, but they are
9 not being counted towards our budget resolution targets.

10 Senator Moynihan. Mr. Chairman, on that Chart 4.
11 Secretary Samuels has been sitting back quietly all
12 morning, as you have done as well, but he will join the
13 table, I hope, as is the custom.

14 The Chairman. It is my intent to keep at the panel
15 just members of the professional staff and not open it up
16 to others. When the administration has a plan, we will be
17 glad to have a hearing and at that time invite
18 representatives to be at the table. But, to be expeditious
19 about it, the hour is growing late, and we do intend to
20 keep at the table the people there.

21 Senator Moynihan. Mr. Chairman, could I ask you to
22 think about that during our break here? I think that would
23 be without precedent. We have always had a Treasury
24 official when we have talked about tax matters. In 19
25 years, it has been a uniform practice. It is not going to

1 do any harm to anybody.

2 The Chairman. I will take it under advisement.

3 Senator Moynihan. Would you?

4 Ms. Paull. In addition, the next item, Item number 4,
5 is the Finance Committee's program share of outlay savings
6 from the Senate-passed H.R. 4. There is no table on that.
7 I have a basic breakdown of those, if members are
8 interested, by program.

9 In addition, there are an additional three proposals
10 that are included in the modification and Tables 5, 6 and
11 7 indicate the savings from those proposals. They will be
12 described in further detail as we talk through this
13 afternoon.

14 With that, I would just add that the remaining piece to
15 the mark-up is the debt limit. It was included in the
16 original mark. Our budget instructions have instructed the
17 committee to report out a debt limit increase from $4.9
18 trillion to $5.5 trillion.

19 The Chairman. All right. The committee will be in
20 recess until 3:00.

21 (Whereupon, at 12:44 p.m., the meeting was recessed.)

22

23

24

25

1 AFTERNOON SESSION

2 (3:19 p.m.)

3 The Chairman. The committee will please be in order.
4 I think a number of additional members will be here in due
5 time. It is my intent to stay here until we complete the
6 walk-through so that we have that behind us.

7 The order in which we will take up the matters on the
8 agenda will be: Medicare, Medicaid, then EITC. And then we
9 have three additional savings proposals: the Social
10 Services block grant, foster care administrative expenses,
11 and, finally, child support enforcement.

12 What I thought we would do is let the staff, starting
13 with Julie James going through a certain portion of her
14 briefing, and then open it up to any and all questions that
15 you may have. Hopefully that will be a more orderly way of
16 proceeding.

17 I do have one question I would like to ask you, Susan.
18 Before I do that, I would just like to say to my colleagues
19 on the other side, we are very fortunate in having a
20 professional staff, in my taking over during this
21 transition, have really done yeoman's service. I could not
22 have asked for greater cooperation and better work. I am
23 deeply indebted to each and every one of them, as I know
24 the whole committee recognizes.

25 Susan, it is my understanding that the preliminary CBO

1 analysis showed that the Chairman's mark--I am making
2 reference to the chart on the left--extended Medicare Part
3 A solvency until 2007. That is what the chart shows there.
4 Do we have any subsequent information on that matter?
5 Ms. Nestor. Yes, we do, Senator. As you know, we
6 have been refining the numbers over the last several days,
7 and with the CBO analysis of our numbers we estimate that
8 the trust fund solvency would actually be extended to 2008,
9 and under the actuary's number, the Chief Actuary, Rick
10 Foster, who was mentioned earlier in the hearing, we
11 believe our solvency would actually be extended to 2009,
12 under our proposal.
13 The Chairman. So that is a total extension of seven
14 years.
15 Ms. Nestor. That is correct.
16 The Chairman. That is very good news.
17 Julie, do you want to proceed, please?
18 Ms. James. Thank you, Mr. Chairman.
19 I am going to begin by discussing the Medicare Choice
20 proposal and I am going to follow through the mark as it
21 was distributed, so I would ask you to turn to page nine.
22 The Medicare Choice proposal is something that builds
23 off of much of the work that has been done in the committee
24 over the past five years, and even longer, in terms of
25 looking at the options and choices that are available to

1 Medicare beneficiaries, allowing them more choice, and also
2 introducing competitive market forces into the Medicare
3 system to help contain costs and make the Medicare program
4 look more like the traditional health care programs that
5 are available to the under-65 population.
6 The Medicare Choice program is modeled very much like
7 the Federal Employees' Health Benefit Program. Basically,
8 Medicare beneficiaries would get information from the
9 Secretary mailed to them once a year.
10 That information would describe the Medicare program
11 and all of the private plan options that are available to
12 the beneficiaries in each area.
13 I want to stress that the Medicare Choice program is
14 completely voluntary, that in this proposal traditional
15 Medicare remains an option throughout the United States for
16 all Medicare beneficiaries.
17 The Medicare Choice proposal builds very much on the
18 existing program within Medicare that allows health
19 maintenance organizations to contract with Medicare and
20 offer services and be at risk for providing Medicare
21 services to beneficiaries.
22 What we would propose to do in this proposal is to
23 expand the option. Right now, that is only available for
24 health maintenance organizations. We would like to expand
25 that option to all types of health plans.

1 As we have heard over the last several years when we
2 have been looking at the health system, we know that all
3 sorts of new types of health plans are evolving. We want
4 to be able to adapt the Medicare program to be able to
5 accommodate any kind of plan that might develop that might
6 serve the needs of beneficiaries.
7 So that would include traditional fee-for-service type
8 plans, or preferred provider organizations that would still
9 allow a lot of flexibility to beneficiaries, coordinated
10 care plans such as health maintenance organizations, high
11 deductible health plans where the beneficiary would be
12 willing to accept a higher out-of-pocket cost up front and
13 then be able to take the difference in the cost of that
14 plan and put it in a medical savings account to use to
15 cover co-payments and deductibles or other health care
16 needs that they might have.
17 I will talk more about the details of the medical
18 savings account option as we get to the end of the document
19 and talk about the options that beneficiaries have in
20 regard to the payment.
21 We also would allow union or association-sponsored
22 health plans, and want to emphasize that most association-
23 sponsored health plans are insured products. This,
24 however, would allow Taft-Hartley union plans as well, if
25 they were interested and can meet all the standards, to

1 participate.

2 So the standards that are required of all health plans

3 in order to participate would be that they be licensed

4 under State laws applicable to bearing risks for health

5 services in every State, and there is the one exception for

6 the union or association plans that are preempted by State

7 regulation.

8 They would have to assume full financial risk for

9 delivering the Medicare benefits to the Medicare

10 beneficiaries, and they would have to meet solvency

11 requirements as defined by the Secretary. I might add that

12 these are all standards that are in current law that relate

13 to health maintenance organizations that we have adapted.

14 On eligibility, all Medicare beneficiaries who are

15 enrolled in Part A and Part B would be eligible to

16 participate. The only exception would be beneficiaries

17 with end-stage renal disease who are on Medicare because of

18 end-stage renal disease. This is, again, the current

19 policy.

20 This is a very vulnerable population, and so we have

21 precluded them from participating at first, and have asked

22 the Secretary to report back to Congress on the

23 implications for enrolling this population.

24 I would note, however, if a beneficiary is enrolled in

25 a plan and very happy with the plan and wishes to remain

1 and they then develop end-stage renal disease, they would
2 be allowed to do so. That is also current policy.
3 As I said, this is the Federal Health Benefits model.
4 The Secretary would send out information once a year, along
5 with enrollment instructions, to each beneficiary.
6 Beneficiaries would choose the plan that they wanted and be
7 enrolled on a first-come, first-served basis.
8 The enrollment would occur through the Secretary,
9 although for all of these activities the Secretary would be
10 allowed to contract with private parties to carry them out.
11 One of the distinctions we have in this proposal from
12 what happens with the current Medicare HMO program is that
13 persons that are newly-eligible for Medicare will receive
14 this information 90 days before their 65th birthday so that
15 at the time that they become eligible for Medicare, they
16 will have these options and be allowed to choose.
17 This facilitates many employees who are retiring who
18 may be enrolled in a plan and wish to remain in that plan,
19 and at this point in time they have to disenroll, enroll in
20 the traditional Medicare program, and then re-enroll in a
21 Medicare HMO.
22 On disenrollment, again, similar to the federal
23 program. This would be an annual occurrence; you would be
24 enrolled for a full year. There are several exceptions.
25 The first time that a beneficiary enrolls in a health plan

1 they have a 90-day period, a trial period, and during those
2 90 days they would be allowed to disenroll from the plan if
3 they were not satisfied.
4 Otherwise, they have to stay in the plan and they can
5 disenroll during the annual enrollment period every year.
6 There are, of course, always going to be exceptions that we
7 would allow the Secretary to define, such as if you move
8 out of area, et cetera, for when you could disenroll.
9 There is also one other exception, and that is for
10 enrollees who choose the high deductible option. We
11 require a one-year notice during the open enrollment period
12 before they can disenroll the following year, so that is
13 effectively a two-year period during which you have to have
14 the high deductible option.
15 The information provided to beneficiaries is critical
16 to this proposal. The Secretary will provide each
17 beneficiary once a year with information which describes
18 the traditional Medicare program, what the Part B premium
19 is, the benefits, the covered items and services, and the
20 cost-sharing in the traditional program.
21 The information will also include a definition of what
22 the payment area is for that beneficiary and what the
23 Medicare payment amount is. That is the amount that the
24 beneficiary can apply towards any of the options that are
25 available in that area.

1 This information will also include information on every
2 health plan that is available so that there is complete
3 disclosure to the beneficiary--this is, again, all
4 controlled through the Secretary--about what the plan has
5 to offer.
6 I do not know if I should list all these out, but it
7 would describe the benefits, the restrictions that the plan
8 has in terms of where the services can be obtained, what
9 happens if they are obtained from providers who are not
10 within the network, what kind of arrangements there are for
11 out-of-area coverage, for emergency services, what the
12 appeals rights are of beneficiaries, and notice that the
13 plan can terminate its contract so that the beneficiary has
14 some idea that that could happen. Again, this is all part
15 of current law.
16 The information provided could also--does not have to,
17 but could--offer supplemental benefits to the
18 beneficiaries, and it could be included in this
19 informational material.
20 For both the traditional Medicare program and for all
21 the plans that are offered, the Secretary is instructed to
22 provide, to the extent available, some quality indicators,
23 such as disenrollment rates, and some information on
24 enrollee satisfaction and outcomes.
25 Marketing. The plans will be allowed to market

1 directly to beneficiaries, just as the federal health plans
2 do today. They can run television ads or newspaper ads, or
3 whatever, but all marketing materials must be submitted to
4 the Secretary for approval so that it is clear that they
5 conform to fair marketing practices.
6 Benefits. On the minimum benefit package. All plans
7 must provide the same covered items and services that are
8 in the traditional Medicare program. The cost-sharing
9 amounts can differ.
10 There is one caveat, that the average cost-sharing per
11 enrollee in one of the plans cannot exceed the average
12 cost-sharing under the traditional Medicare program. There
13 is an exception for this, for the high-deductible plans.
14 The plans can offer additional benefits as part of
15 their basic package, so they would be allowed to offer a
16 package that included prescription drugs, for example.
17 They may also offer supplemental benefits to beneficiaries
18 for an additional premium, and the only requirement there
19 is that they offer the supplemental benefits to all
20 beneficiaries and that they rate them the same.
21 There are several more rules here that are all current
22 law that have to do with allowing the plans to bill
23 Worker's Compensation or other kinds of insurance plans, et
24 cetera.
25 Now, all plans must meet the same quality standards.

1 They are all required to have an ongoing quality assurance
2 program. We have tried to introduce some flexibility here
3 in allowing the Secretary to deem or establish that there
4 are certain accrediting organizations out there, and if the
5 accrediting organization approves the plan and those
6 standards are equal to or better than the Medicare program,
7 that they would be accepted by Medicare.
8 The plans have to have sufficient capacity. They have
9 to demonstrate that they have capacity to take care of the
10 number of enrollees that they have. There are certain
11 access standards in terms of how the care must be
12 delivered, that it must be accessible 24 hours a day and
13 seven days a week for urgent care.
14 We have defined service areas for the plans to conform
15 to the Medicare payment areas. However, we realize that
16 this might not be appropriate for all of the plans, so we
17 leave it to the Secretary to be able to waive that
18 requirement and redefine the service area as long as the
19 Secretary ascertains that the plan is not engaging in any
20 sort of discriminatory activity by defining its service
21 area.
22 Consumer protection standards include requiring the
23 plans to accept every enrollee without any regard for the
24 health status of the enrollee, guaranteed renewal; they
25 cannot disenroll a beneficiary, they must have grievance

1 procedures. In the case that a plan terminates, they must
2 arrange for six months of coverage under a supplemental
3 plan for a beneficiary who needs it.
4 There are also standards for provider compensation and
5 what plans must do in terms of compensating their providers
6 on a timely basis. There is also, as under current law, a
7 requirement that the plans require information on advance
8 directives, which are the instructions that relate to what
9 to do in cases of serious illness.
10 Now, the most crucial part of this proposal are the
11 payments that will be made and available to beneficiaries
12 to apply towards their health plan options. Right now, we
13 have the system that is referred to as the AAPCC, or the
14 Average Adjusted Per Capital Cost. There have been a
15 number of problems with this system.
16 The payments are calculated on a county basis. They
17 relate directly to the spending in the traditional Medicare
18 fee-for-service program. They vary dramatically across the
19 United States. The range in 1995 ranges from $177 a month
20 to $679 a month, which is over $500.
21 The rates are also not stable, even though there might
22 be a percentage increase of seven, eight, 10 percent
23 overall on average across the United States, the actual
24 increases from county to county can be a negative increase
25 or range all the way up to 60 percent or higher.

1 There is an instance with the new rates for 1996 that
2 were just published of the county of Loving, Texas, which
3 has a 141 people in it. Its rate last year was $501, and
4 its rate this year, in 1996, is scheduled to be $876. So,
5 that is, I think, over a 60 percent increase.
6 So that instability in the rates has caused a problem
7 with having health plans go into a lot of markets, because
8 they need to be able to count on some relative stability in
9 the rates in order to plan, to develop a program, and
10 enroll beneficiaries in a market.
11 I now would like to refer you to page two of the
12 modification that was handed out earlier. We have been
13 working diligently to come up with a payment system that
14 would solve a lot of the problems that we have with the
15 current system.
16 One of the primary things that I want to point out is
17 that we will de-link the payments on he Medicare Choice
18 side from the traditional system. So we will start by
19 looking at what the payments are today and we will make
20 some adjustments, but then at a point in the future when we
21 establish a base payment amount for each area, that payment
22 amount will be indexed and grow at the same rate across the
23 United States.
24 I am going to describe the transition now that we have
25 for determining what the base rates will be. For next

1 year, in 1996, we will look at the 1996 rates that have
2 just been published. These are based on projected Medicare
3 spending.
4 As a result of this legislation, projected Medicare
5 spending will go down, so we will recalculate those rates
6 to incorporate the reduced increase in spending. I will
7 say that the overall increase for 1996 was over 10 percent.
8 We will then apply a blend of National and local rates
9 in order to begin to narrow the range. For 1996, the range
10 is actually over $600. What we will do, is we will take
11 the local rate and we will weight that at 75 percent, and
12 then we will take the National rate, and this will be a
13 National rate that is adjusted for the differences in
14 prices across the United States, so that there will be
15 recognition of the fact that there are price differences
16 across the United States. That will determine the rate for
17 1996, and that will still be paid to Medicare HMOs on a
18 county basis.
19 Then beginning in 1997, when the Medicare Choice
20 program is implemented, we will make several more changes
21 that will result in a stabilization and an equalization of
22 these rates across the United States. We will further
23 blend the rate at a 50 percent local/50 percent National
24 level. We will aggregate the now county-level rates into
25 larger regional rates.

1 These regions will consist of metropolitan statistical
2 areas, which are the urban areas across the United States,
3 and in cases of large, consolidated metropolitan
4 statistical areas like Washington, D.C. and Baltimore, we
5 will use the primary metropolitan statistical area
6 designation so that Baltimore and Washington, D.C. would be
7 in two separate areas.
8 We will also remove one-half of the amount of payments
9 that are made for medical education and disproportionate
10 share spending. I want to emphasize right now, when the
11 calculation is made to determine the rate, all of the
12 Medicare spending in an area is considered.
13 That spending includes payments that go for medical
14 education and disproportionate share. That money is
15 intended to go to teaching institutions and institutions
16 that treat a lot of uncompensated care.
17 Right now, that is incorporated into the rate that goes
18 to the health plan without any regard as to whether the
19 health plan actually contracts with the teaching
20 institution.
21 So this is to make adjustment for that and make sure
22 that the money that was intended to go for teaching and
23 subsidizing uncompensated care actually does go to those
24 institutions.
25 So what we are doing is pulling that money out of the

1 calculation for the Medicare payment amount and we will
2 allow hospitals that qualify for these payments to submit
3 a claim to Medicare whenever they treat a patient who is
4 enrolled in a private Medicare Choice plan and get the
5 amount of payment that they would otherwise get for
6 treating a traditional Medicare payment for medical
7 education and disproportionate share.
8 So they would not get the payment for delivering the
9 care, but they would get the medical education and the
10 disproportionate share payment. The amount they get for
11 delivering the care would be negotiated with the health
12 plan.
13 We will remove half of that in 1997 and the other half
14 in 1998. At that point, according to preliminary analysis,
15 the range in payments will be significantly narrowed. We
16 have asked the Secretary to look at the variation then
17 across the United States, do an analysis, and report to
18 Congress in 1999.
19 If the Secretary determines that certain further
20 adjustments need to be made to equalize these rates, then,
21 unless Congress acts, the Secretary can make those
22 adjustments beginning in the year 2000, and to complete
23 those adjustments by the year 2002, so that by 2002 we
24 would have the base rate established, and from there those
25 rates would be indexed every year.

1 We have indexed the rates to grow. Of course, Congress
2 can always act to determine what the update will be, but
3 the update that we have in this formula would be the per
4 capita growth in the gross domestic product.
5 Payments to the health plans will be risk-adjusted, as
6 they are today under the Medicare HMO program, so that
7 differences in health utilization that are accounted for by
8 differences in age, sex, and whether or not the patient is
9 on Medicaid and whether or not they are institutionalized
10 will be done by the Secretary so that the amount of money
11 that is actually sent to a health plan may be different
12 than the standardized rate that would relate to an average
13 mix of beneficiaries.
14 This is to protect health plans so that those who may
15 get more older patients, poorer patients, will get a higher
16 payment than those who get younger patients and patients
17 that would be less poor.
18 Now, the payment amount will be standardized across the
19 country and the beneficiary will know how much that is in
20 their area. Then each health plan that wants to
21 participate will submit their premium price for the plan.
22 And if there is an additional amount that is due from the
23 beneficiary, if they choose a plan that costs more than the
24 standard amount that Medicare will pay in the area, then
25 the beneficiary has to pay that difference.

1 If they choose a plan that costs less, the beneficiary
2 has a series of options. They can take 100 percent of that
3 amount of difference and they can put it in a medical
4 savings account.
5 You do not have to have the high-deductible plan to
6 have a medical savings account. You do, however, have to
7 have a medical savings account if you have a plan that has
8 a deductible of more than $3,000.
9 But any beneficiary can take their excess amount and
10 put it into a medical savings account, or they can instruct
11 the Secretary to send the additional amount to the health
12 plan to pay for supplemental coverage. For example, if
13 there is a dental plan or something they would like to
14 enroll in, they can have that money applied towards that.
15 In those cases, the money is not taxed.
16 If the beneficiary would like to have a cash rebate at
17 the end of the year, we also allow that. That cash rebate
18 would be equal to 75 percent of the difference, and the
19 other 25 percent would be returned to the Part A trust
20 fund.
21 I would like to describe now the medical savings
22 account option. The rules for this would be very similar
23 to an IRA. We did not define a specific deductible level,
24 we just have set a threshold of $3,000 for the size of the
25 deductible.

1 If the plan has a deductible of $3,000 or more, then
2 you must have the medical savings account, and we have put
3 a maximum on that of $6,000. But the $6,000 is total out-
4 of-pocket spending to the beneficiary for the Medicare
5 benefits, items, and services.
6 So, for example, you could have a plan that has a
7 $5,000 deductible and then allows up to $1,000 of co-
8 insurance. Then when the beneficiary has spend the $6,000,
9 then the plan would cover all expenses. That was, again,
10 to provide for some flexibility in terms of plan design.
11 The money in the medical savings account can be used
12 for any health medical purpose, as defined in the Tax Code
13 under Section 213, with the exception of health insurance
14 premiums. We also allow it to be used for long-term care
15 insurance premiums. For any of those uses, the money can
16 be withdrawn tax-free.
17 If the beneficiary wants to withdraw the money and use
18 it for a non-medical purpose, then they can do that, but
19 there is a 10 percent penalty and that amount of money is
20 then subject to tax. The medical savings account balance
21 can build up from year to year, but the interest is taxed.
22 Senator Moynihan. Mr. Chairman, could I ask Ms.
23 James, do we have any revenue numbers on the medical
24 savings account?
25 Ms. James. No, Senator, we do not.

1 Senator Moynihan. They are coming. All right.

2 Ms. James. I just will mention, in conclusion, that
3 we are grandfathering in the existing Medicare HMOs so they
4 can have up to three years to meet any new standards that
5 they might have to meet to be Medicare Choice plans, and
6 then, beginning in January of 1997, the Medicare Choice
7 program gets under way.

8 I would be happy to answer any questions.

9 The Chairman. Are there any questions?

10 Senator Graham. Yes, Mr. Chairman.

11 The Chairman. Senator Graham.

12 Senator Graham. Mr. Chairman, I have some questions
13 on the presentation that has just been made. But, before
14 I turn to those, I would like to ask a procedural question.

15 I have an amendment which I would hope to offer at some
16 point relative to a trade issue. It is my understanding
17 that the Chair might be disposed to hold trade-related
18 issues until the next mark-up, which relates to taxes, as
19 opposed to considering them at this time. Is that correct?

20 The Chairman. Yes, that is correct. We have not made
21 any final decision as to what we are going to do, but if we
22 take up the matter, it will be in the next mark-up.

23 Senator Graham. I did not want to get in the position
24 of not offering it now and then find out later that I
25 should have offered it now.

1 The Chairman. Sure.
2 Senator Graham. So you suggesting it would be more
3 appropriate and germane to do it the next round than at
4 this time?
5 The Chairman. That is correct.
6 Senator Graham. Thank you, Mr. Chairman.
7 On the subject before us, could you, in general,
8 indicate what are the differences from the current policy
9 relative to health maintenance organizations and Medicare
10 from those which will be incorporated in the Medicare
11 Choice plan?
12 Ms. James. Senator, the major differences are the
13 types of health plans that can be made available to
14 Medicare beneficiaries. Right now, it is only health
15 maintenance organizations. This will allow any type of
16 health plan that meets the standards to qualify.
17 Senator Graham. Would this allow, for instance, what
18 is called direct contracting HMO plans, that is, where
19 hospitals and physicians form a service group and do not
20 use a financial intermediary, but would contract directly
21 with HCFA?
22 Ms. James. Senator, it does allow physician-hospital
23 networks to be plans. However, it does require that they
24 be State-licensed as insurers.
25 Senator Graham. How many States currently license

1 those types of plans?

2 Ms. James. Well, a critical issue here is trying to
3 define the difference between a physician-hospital network
4 and a health maintenance organization and what that
5 distinction would be.

6 It is important that this proposal requires that a plan
7 accept full risk for all of the Medicare items and services
8 that are provided to a beneficiary so that once a
9 beneficiary enrolls in the plan, that plan is at full risk,
10 but the traditional Medicare program is no longer at risk.
11 That risk is the business of insurance.

12 Right now there is a considerable discussion under way
13 across the States about whether or not physician-provider
14 networks are, indeed, insurance and should be regulated as
15 such, are they health maintenance organizations and should
16 be regulated as such, so this is receiving a lot of
17 attention.

18 This proposal builds on the current system where health
19 insurance is regulated at the State level, so we require
20 that State licensure. We are very concerned that these
21 plans are solvent and have some experience before they are
22 enrolling this population, so that is why we have gone with
23 the State licensure requirement, as in current law.

24 Senator Graham. I am sorry, I interrupted. You were
25 answering the question of differences between the status

1 quo with Medicare HMOs and what will be available through
2 this plan.
3 Ms. James. So it would be the types of plans that are
4 available. And the whole structure, I think, of the
5 payment mechanism is the significant difference from the
6 current system, the current county-based that is based on
7 traditional spending on average in an area and moving to
8 this new payment situation. There are several changes in
9 the standards, although I would have to say, by and large,
10 most of these standards in here are from the traditional
11 program.
12 We are concerned that plans be allowed to enter into
13 this market and compete, and so we have done away with the
14 50/50 rule, which required that a plan could not have more
15 than 50 percent of its population Medicare and Medicaid
16 enrollees. Those are the major differences. The medical
17 savings account, obviously, is one of the plan options.
18 Senator Graham. One of the concerns about the status
19 quo is the prevalence of adverse selection. That is, where
20 people who are in relatively good health will select into
21 HMO plans, and those that are not in good health will stay
22 with the standard fee-for-service. What have you done to
23 try to guard against that phenomenon?
24 Ms. James. Well, Senator, that is an issue that this
25 committee has been struggling with for several years now.

1 It is a very serious issue. We have done several things in
2 this plan to address that.
3 First of all, is the enrollment process. We have a
4 centralized enrollment process, where the Secretary is
5 doing the enrolling and people can enroll in a plan on a
6 first-come, first-served basis.
7 So, to the extent that there is any concern about the
8 way that health plans may market or target populations, or
9 whatever, that is eliminated. We also have made a change
10 from the current situation where an enrollee can disenroll
11 at any time.
12 We now require an annual commitment by the enrollee,
13 except for the initial trial period, so that there cannot
14 be movement back and forth. There has to be a serious
15 commitment to be with the plan.
16 I am sorry. We have the risk adjustment, and we have
17 asked the Secretary to use a health status risk adjustor.
18 The department has been doing a lot of research on risk
19 adjustment, as has many people across the United States,
20 and certainly we know that we do not have a perfect risk
21 adjustor. If we did, then we would not have risk anymore.
22 So we have asked the Secretary to go ahead and use and
23 apply a risk adjustor to the payments, and we have left
24 discretion to the Secretary as to how to do this.
25 Senator Graham. Mr. Chairman, one last question.

1 One of the concerns with the status quo is also that
2 the Federal Government has not been getting the financial
3 benefit of the use of health maintenance organizations.
4 There is some evidence that, in fact, it may be more
5 expensive to the Federal Government for the enrollees in
6 the managed care plans.
7 I was interested in an article in either today or
8 yesterday's Washington Post about what is happening in
9 Arizona relative to Medicaid. They indicated that one of
10 the keys to the fact that the State of Arizona--and
11 therefore the Federal Government--is benefitting by that
12 program of managed care, is very aggressive negotiation by
13 the State with managed care. They do not use a formula
14 basis, but rather negotiated contracts, if I read the
15 article correctly.
16 A) Under your plan, how will the Federal Government get
17 the financial benefits of people moving into managed care,
18 and B), did you consider using a negotiated basis at
19 arriving at the contracts with health maintenance
20 organizations, whether through competitive bids or direct
21 negotiations, in lieu of this formula?
22 Ms. James. Yes, Senator. We have called for the
23 Secretary to do a competitive bidding demonstration in this
24 proposal. But we did not feel that we were at a point in
25 time yet where we could simply move to a system where the

1 amount of Medicare payment would be based on a competitive
2 bid.
3 We do not have the Secretary giving aggressive
4 negotiating powers in this system. The way it is designed,
5 Medicare will determine the amount that it will pay in each
6 area and that will be de-linked from whatever spending is
7 in the rest of the system.
8 Then through competition the beneficiary will decide,
9 and the competition among the plans will determine what the
10 prices of those plans are. But, in whatever case, the
11 amount of money paid by the Medicare program that goes
12 towards the beneficiary will be a fixed amount.
13 Senator Graham. So the beneficiary will get the
14 benefit of a differential between what they will receive
15 from Medicare and what they will pay for their plan.
16 Ms. James. Yes.
17 The Chairman. Is that not at 75/25?
18 Ms. James. If there is a cash rebate, it is a 75
19 percent rebate.
20 The Chairman. Senator Breaux?
21 Senator Breaux. Thank you, Mr. Chairman.
22 I think in response to Senator Moynihan's question
23 that, with regard to the medical savings accounts, that you
24 do not have a scoring on that.
25 Ms. James. The medical savings account was scored as

1 part of the Medicare Choice proposal in total. So if you
2 look on your chart on page two under Medicare Choice, they
3 have taken into account ----
4 Senator Breaux. But you do not know then whether that
5 increases the cost of Medicare or decreases the cost of
6 Medicare, because that was not considered separately?
7 Ms. James. I understand, from discussions with CBO,
8 that there was some offset to the savings amount that was
9 due to medical savings accounts.
10 Senator Breaux. How much is that?
11 Ms. James. They did not tell me, I am sorry.
12 Senator Breaux. If they had a number, you would
13 presume they would be anxious to tell you.
14 Ms. James. Well, they did not give an indication.
15 There were so many offsets going on in the proposal when
16 they were scoring it. There is a footnote that has to do
17 with medical savings account, footnote number four on page
18 three.
19 Senator Breaux. What does that footnote say?
20 Ms. James. I am sorry. It says that, "the effects of
21 medical savings account provision are embodied in the
22 Medicare Choice line."
23 Senator Breaux. So there is a secret number somewhere
24 and we do not know what it is.
25 Ms. James. Senator, I will call and ask them for a

1 specific answer to that.

2 Senator Breaux. That point I want to make is, I
3 thought medical savings accounts were a wonderful idea when
4 I first heard about them. Then I have become convinced,
5 the more I read about it, is that it is great if you are
6 healthy and it is bad if you are sick.

7 When this proposal takes it and puts a medical savings
8 account as part of Medicare, I think there is a real
9 concern that we should have as a committee that, in fact,
10 we may be raising the costs of Medicare.

11 Now, if you have it in the private sector where
12 somebody is working and their employer contributes, that is
13 one thing. But with this, we are saying for the first time
14 that Medicare, I guess, is going to contribute to that
15 savings account.

16 If all of the healthy people on Medicare get sucked
17 into the medical savings account because it is a good deal
18 for them if the government puts money in their savings
19 account and they never spend it and they get to keep it,
20 that is a heck of a good deal.

21 So if the healthy people move into a Medicare medical
22 savings account, what you are left with in the regular
23 Medicare fee-for-service is sick people, you are going to
24 actually be costing Medicare more by instituting a medical
25 savings account for Medicare patients.

1 Now, give me some comment on that.

2 Ms. James. Well, Senator, for one thing, there are
3 certain characteristics of the high-deductible option plan
4 that may appeal to people over the traditional plan.

5 Senator Breaux. Sure. If you are healthy, it is a
6 hell of a deal.

7 Ms. James. No, because there is a $6,000 total out-
8 of-pocket cap which does not exist now in the traditional
9 program. If you are ill and you have built up your
10 account, you will have money in there to cover your
11 expenses. You would also have money to cover certain
12 things, such as prescription drugs, that would not be
13 available under the traditional system.

14 So, this is an option for beneficiaries. It is risk-
15 adjusted, just like the payments to all types of plans will
16 be. There is also the extra disenrollment requirement on
17 these plans so you simply cannot, the minute that you get
18 ill and you decide you want to opt back into the
19 traditional program, do that. You have to give us one year
20 notice and stay in the plan for a year.

21 Senator Breaux. But is there not a problem--I do not
22 want to prolong this--if healthy Medicare patients move
23 into the medical savings account and the sick Medicare
24 patients stay in the current fee-for-service program? Is
25 that not a problem and a risk of having higher Medicare

1 costs in total?

2 Ms. James. There are a number of things in this

3 proposal to try to guard against that, such as risk

4 adjusting the payment, and we will have to monitor that.

5 Senator Breaux. Added to that concern, we do not have

6 CBO telling us whether this is an actual savings or whether

7 this is an increase. They just said it was factored in in

8 the big picture, but it does not say what their opinion of

9 what medical savings accounts would do from a cost

10 standpoint or a savings standpoint. That is correct, is it

11 not?

12 Ms. James. I do know that they assigned some cost.

13 Senator Breaux. But we do not know whether it was a

14 plus or a minus.

15 Ms. James. No. We do know that the savings that we

16 got from Medicare Choice in total have been higher.

17 Senator Breaux. Oh, sure. But I am talking about

18 medical savings accounts as an ingredient in that. Then

19 they have the whole picture.

20 Ms. James. They would have had higher savings had

21 they not done a discount on our savings number for the fact

22 that they considered some adverse selection from medical

23 savings accounts. I just wanted to clarify that.

24 Senator Breaux. All right. So are you telling me

25 that when they considered the medical savings account they,

1 in fact, scored it as costing more?

2 Ms. James. Slightly, they told me. Yes.

3 Senator Breaux. So here we have something in budget
4 reconciliation, where we are trying to save money, that we
5 now find is going to cost money.

6 Senator Moynihan. Mr. Chairman, if I could just
7 interrupt the sequence.

8 The Chairman. Sure.

9 Senator Moynihan. Pursuant to Senator Breaux's
10 comment, Secretary Samuels, could you give us some Treasury
11 sense of the tax provisions for withdrawal from a savings
12 account and the taxation of interest built up internally
13 that is subject to taxation. I do not have any
14 prejudgment, but does this sound simple to you?

15 Secretary Samuels. Senator Moynihan, we have been
16 looking at the medical savings account proposals and have
17 serious concerns about the administerability of the
18 proposals. This was mentioned, in describing medical
19 savings accounts, as in addition to IRAs, so it is a brand-
20 new vehicle. But, unlike IRAs, the inside build-up is
21 subject to tax.

22 So we are going to have to figure out a way to report
23 to the beneficiaries, as well as the Internal Revenue
24 Service, the inside build-up and, for example, if you have
25 a loss inside your medical savings account, you are only

1 supposed to use it against future income of the medical
2 savings account. So we are very concerned about the
3 complexity, and we are actually doing mock-ups of forms to
4 show the committee how complex the proposal would be.
5 Senator Moynihan. Well, Mr. Chairman, I think that is
6 a question that I think we want to get to. How many of
7 these are we going to have, 20 percent of the total, would
8 this be?
9 Ms. James. No, Senator.
10 Senator Moynihan. Do we have any idea how many we
11 will have, a million, five million?
12 Ms. James. The 20 percent figure was the total amount
13 of people enrolled in Choice plans.
14 Senator Moynihan. In Choice plans.
15 Ms. James. Yes. I do not know. I apologize. CBO
16 did not think it would be an option chosen that often, so
17 that is the extent of the number now.
18 Senator Moynihan. All right. Well, let us keep in
19 touch with those people at CBO.
20 Ms. James. All right. Yes, we are.
21 Senator Moynihan. Thank you, Mr. Secretary.
22 Senator Rockefeller. Mr. Chairman.
23 The Chairman. Yes, Senator Rockefeller.
24 Senator Rockefeller. Thank you, Mr. Chairman. Let me
25 just say to my colleague from Florida as to the provider-

1 sponsored networks, I will be offering an amendment on that
2 tomorrow and perhaps we could do that together.
3 Following up a little bit on what Senator Breaux was
4 talking about. First of all, I want to commend you, Julie
5 James. You have been doing a really skillful, good job.
6 Ms. James. Thank you.
7 Senator Rockefeller. You really have. I mean, it is
8 quite distinguished.
9 Gail Wilensky, Stuart Altman, GHAA, Blue Cross/Blue
10 Shield, and I do not know who else, expressed their concern
11 about the MSA proposal based upon what Senator Breaux was
12 talking about, and that is the so called viable risk
13 adjustment mechanism.
14 Now, you have used phrases like "risk adjusting the
15 payment" --
16 Ms. James. Yes.
17 Senator Rockefeller. -- even as you have been saying
18 what is true. That is, nobody has been able to do it. It
19 will be several years. This is not a question of HCFA
20 being slow or having 4,000 people or four people, They are
21 not going to have a risk adjustment worked out. It is one
22 of the hardest things to do--Einstein could not do this--
23 but you put it in as a given in your proposal.
24 That is great if it works out, but I am told that if
25 you cannot risk adjust on an individual health policy, you

1 get into big trouble. The main part of that trouble, I
2 think, would be what the Senator from Louisiana indicated,
3 and that is that Medicare would end up paying more money
4 because the sick people would stay in Medicare and the
5 wealthy and the healthy would go into the MSA, Medicare
6 Choice, or whatever. I worry very much about that.
7 In 1993, more than 40 percent of Medicare beneficiaries
8 had an average per capita spending of $1,858; almost six
9 percent had no Medicare reimbursement made on their behalf
10 between 1990 and 1993. If those beneficiaries chose the
11 MSA option, would that not end up costing Medicare a lot
12 more money?
13 Ms. James. If you had all the sick people staying in
14 traditional Medicare and all the healthy people going out,
15 it may, but we do not have any indication that that is what
16 would happen.
17 There are a whole series of risk adjustment factors
18 that will be used that they are using currently with the
19 program, which include age, sex, and whether you are on
20 Medicaid and whether you are institutionalized. The health
21 status is the factor that is the most difficult one to
22 crack, if you will.
23 There has been a lot of work done across the Nation on
24 this. You can do it prospectively or you can look back and
25 see what people actually did and then make an adjustment.

1 The Secretary would have the authority to employ, to the
2 best of her knowledge at this point, what kind of health
3 status adjuster might work the best.
4 There has been some experience in New York with
5 adjusting just on major illness categories, some of the
6 very costly ones. I am not sure that we will ever have a
7 perfect risk adjustment system.
8 Senator Rockefeller. I just kind of wonder about
9 going forward when we really do not know.
10 Under current Medicare law, seniors who are enrolled in
11 an HMO and receive care from a doctor who is not a member
12 of an HMO have balance billing protections. Balance
13 billing is still a subject. Are similar current balance
14 billing protections available to seniors who enroll in
15 other management care plans under the Chairman's mark?
16 Ms. James. First of all, Senator, we are opening this
17 program up to all sorts of plans, so it is not only managed
18 care plans. There will be all sorts of plans that will be
19 able to participate.
20 The fundamental part of this is that the beneficiaries
21 will be provided with information on what each plan covers
22 and what they will be responsible for covering so the same
23 balance billing protections that are under the traditional
24 program will not necessarily translate to the Medicare
25 Choice plans.

1 They will decide and determine what their benefit
2 package is, how they reimburse providers and how much, and
3 what the beneficiary is responsible for, and that
4 information will be provided to the beneficiary.
5 Senator Rockefeller. So what you are basically saying
6 is, they will have better information, but the current
7 balanced billing protections, as they are today, will not
8 be there.
9 Ms. James. Those requirements will not apply to the
10 Choice plans.
11 Senator Rockefeller. Right. That is what I thought.
12 Can you compare--and then I will just have one more
13 thing to say, Mr. Chairman, and then I will be finished--
14 the growth factor to CBO's projections for private health
15 insurance premiums? CBO--and I have got some numbers down
16 here--projects the following increases in private health
17 insurance premiums over the next seven years. It goes, in
18 1996, from 5.8 to 6.9 in 1997, 7.6, and hovers in that
19 area.
20 I think that with your capped payments for Medicare
21 Choice plans--at least, that is the phrase I would use--you
22 have what is a nominal growth rate as opposed to a real
23 growth rate, which would be nominal minus inflation.
24 The nominal growth rates, however, are substantially
25 lower in all cases through the year 2000. When I say

1 substantially, I mean one percent to sometimes close to two
2 percent. How can we cap Medicare's payments to private
3 plans on behalf of Medicare beneficiaries at a rate which
4 is lower than even private sector growth rates?
5 Ms. James. Well, Senator, it is very difficult to
6 make an apples-to-apples comparison of what the Medicare
7 rates would be to private sector employer health plans
8 because of differences in benefits and a different
9 demographic population. We do have the growth in the per
10 capita rate growing at per capita GDP, which is projected
11 to be about 4.3 percent, and we chose this because this is
12 an indication ----
13 Senator Moynihan. That is 4.3, nominal.
14 Ms. James. Yes.
15 Senator Moynihan. Yes.
16 Ms. James. We selected this because this was an
17 index, an indicator, of the relative strength and growth in
18 the economy and what the government could afford. The
19 update could be changed or set by Congress every year.
20 This is a default update. This is if Congress does not act
21 what would happen.
22 If the update is not enough, we might have less. The
23 premiums might go up and we might have fewer people
24 enrolling, and Congress could do something about that. I
25 mean, I guess what I am trying to say is, that is an index

1 that happens in case Congress does not act to set what
2 these updates will be every year.
3 Senator Rockefeller. No. I understand that.
4 Ms. James. We did not want to err on the side of too
5 much.
6 Senator Rockefeller. Yes. Well, you did. I just
7 want to be clear about that. For example, in 1999 there is
8 a 2.5 percent difference lower in the nominal growth rate
9 than in the private insurance premium.
10 If Medicare is going to have your frailer, your sicker,
11 your most expensive, and it is, it is, it is, we all know
12 that, we all are admitting it to each other in coded terms
13 it would be the case, then we are saying, we will reimburse
14 you much less, even in Medicare, than we do in the private.
15 I think that comes from the so called capped payment
16 system. You would not call it that, but that is what I
17 would call it.
18 Ms. James. Well, I hope I did not say anything to
19 imply that I believed that the older, sicker people would
20 necessarily all be in the traditional program. I think
21 that what we are allowing here is a system that ----
22 Senator Rockefeller. But is that not the pattern? Is
23 that not what has been happening, it is 10 percent so far
24 and you are projecting 20 percent?
25 Ms. James. Well, I think CBO made a very conservative

1 estimate. But I think that much of what we have done here
2 is to exposure seniors to what their options are.
3 And, because we fix the payment rate, if you will,
4 geographically, we will make these markets much more
5 attractive to plans and we will have health plans that will
6 go into areas and try to develop products that will appeal
7 to the Medicare population. Right now we are dependent
8 upon the health plans to do the marketing.
9 There is nothing that will be comparable to what we
10 have here, where every year the beneficiaries will be given
11 this information from the Medicare program and there will
12 be an assertive effort to allow the beneficiaries to have
13 access to these plans, which does not really happen right
14 now.
15 Senator Bradley. Could I follow up on that Jay, if
16 you are finished?
17 Senator Rockefeller. I have not, but go ahead.
18 Senator Bradley. It seems to me that what Jay is
19 saying and what you are confirming is that Medicare will
20 pay less and private premiums will pay more. Therefore,
21 you would be pushing people into plans where they would be
22 paying higher premiums, right?
23 Ms. James. Senator, there is nothing in this proposal
24 that would push anybody out of the traditional Medicare
25 program. If they prefer that, they can be in that program.

1 Senator Bradley. But the Medicare capped grant will
2 not be enough to pay for their HMO.
3 Ms. James. Well, there is nothing to suggest that
4 that would be the case.
5 Senator Bradley. Except that the capped grant is much
6 less than the increase in private premiums. Therefore, if
7 you see private premiums are going up but you have capped
8 the Medicare grant down here, then that means higher
9 premiums for the individual. I do not see how you can
10 reconcile those two numbers and come up with anything other
11 than higher premiums.
12 Ms. James. It is very difficult to compare the
13 private.
14 Senator Bradley. Was that your point, Senator
15 Rockefeller?
16 Senator Rockefeller. Well, Senator Bradley, the
17 conclusion that I philosophically conclude with is that
18 this shows that this was a budget-driven decision. This
19 was done in order to achieve a budget result, as opposed to
20 achieve a policy result. I think what this does, is
21 clearly show that. I am finished.
22 The Chairman. Senator Moynihan.
23 Senator Moynihan. Yes. In this same area, I think I
24 have it right that at present about nine percent of our
25 Medicare population are in HMOs.

1 Ms. James. Yes.

2 Senator Moynihan. And CBO projects a rise to about,
3 what is it, 14 percent?

4 Ms. James. 14 percent, under current policy.

5 Senator Moynihan. Under current policy. Exactly.
6 And you want to get up to 20.

7 Ms. James. Actually, I need to correct that. It is
8 between 20 and 25 percent.

9 Senator Moynihan. Between 20 and 25.

10 You are being wonderfully open. That is half again
11 what we now project, 16 as opposed to, say, 24 or 23.

12 Ms. James. I think that the way that we have outlined
13 the proposal where there is this assertive effort by the
14 administration to provide ----

15 Senator Moynihan. You do not mean those terrible
16 government bureaucrats, do you, coercing the population of
17 aged, blind, lame?

18 Ms. James. No. I think that there will be a very
19 positive effort to provide Medicare beneficiaries with
20 information once a year on what their options are and the
21 types of plans that are available to them. That will do a
22 lot to increase participation.

23 Another reason that we do not have as much
24 participation right now as we might is because of the
25 payment methodology and the fact that, in many areas of the

1 country, the way the payments go right now, there is so
2 much variation and they are so low in so many areas, that
3 it is difficult for private plans to develop in those
4 areas.

5 Senator Moynihan. Yes. Yes.

6 Ms. James. And we have done a number of things here
7 to fix that with the payment method.

8 Senator Moynihan. All right.

9 Ms. James. In addition, the whole health care system
10 is changing very rapidly. Enrollment of the under-65
11 population has spurred a lot of health plan providers
12 getting together, HMOs forming, all different types of
13 products, that are available to the whole population. The
14 Medicare beneficiaries have not had access to that range of
15 options before. There will be increasing comfort with
16 people, as they age into the Medicare program ----

17 Senator Moynihan. To stay in an HMO that they have
18 always been in.

19 Ms. James. Right. Right. And also, as providers
20 move into these plans, their patients will move with them.
21 So I think there are a number of things that are happening
22 that will cause this transition to occur.

23 Senator Moynihan. I guess we would like to have your
24 best judgment about what would happen if this does not
25 work. I mean, I can see the case when Medicare began, fee-

1 for-service was the only thing anyone knew and the people
2 did what they knew. Now HMOs are so much more widely
3 available. People might again stay with that they know.
4 But, still, that is a big increase.
5 Ms. James. To go the 22 percent.
6 Senator Moynihan. Yes.
7 Ms. James. I mean, right now, the enrollment in the
8 system, as it is, is one percent increase a year, so there
9 is a 12 percent increase in enrollment a year. One percent
10 a month, I am sorry.
11 Senator Moynihan. One percent a month.
12 Ms. James. One percent a month, 12 percent a year.
13 Senator Bradley. Mr. Chairman?
14 The Chairman. Yes, Senator Bradley.
15 Senator Bradley. If I could just follow up on that.
16 With the higher premiums in the private plans and the
17 capped Medicare grant, and the assumption being that these
18 premiums will come down in the private sector as there is
19 competition, and you have asserted that that is what you
20 expect to happen, that might, indeed, happen, why would you
21 not simply cap the private premiums at the per capita
22 growth of GDP just as you have capped the Medicare
23 payments?
24 Ms. James. You mean, private sector health insurance
25 premiums?

1 Senator Bradley. Yes.
2 Ms. James. Senator, this proposal deals with the
3 Medicare program.
4 Senator Bradley. Right. But the point is here, you
5 have essentially got a Medicare cap that is based upon one
6 criteria, per capita growth of GDP, and, as Senator
7 Rockefeller said, you have projections of private premium
8 increases that are much higher than that, which means that
9 senior citizens will get a capped grant to help pay for
10 their Medicare and, because the premiums are going to go
11 much higher than their capped grant, they will end up
12 paying higher premiums.
13 Ms. James. Well, Senator, first of all, we do not
14 know that the premiums are going to go that high.
15 Senator Bradley. All you had were the projections.
16 Ms. James. That is right. But we also only have
17 projections on the private sector side of health care
18 premiums, and it is very difficult to make a comparison of
19 what happens in the private sector and what happens in the
20 Medicare program.
21 With the rates of growth in the Medicare program and
22 with the particular problems of that demographic
23 population, if you assumed that the Medicare program was as
24 efficient as it could be, then that would say one thing
25 about at what rate you allow it to grow.

1 But, if you assume that there are still inefficiencies
2 in the system that competition and changing incentives
3 could wring out of the system, then the per capita growth
4 in GDP might be very adequate amount to allow those plans
5 to grow every year.
6 Again, we are not capping the amount of the plans, we
7 are not capping their premiums, we are establishing what
8 the Medicare payment amount will be for the plans.
9 Senator Bradley. Right. But that has the same
10 effect. I mean, you are not, per capita, doing it. But if
11 you cap the total, you are pushing people into plans that
12 cost less. Otherwise they will not be able to purchase
13 health care.
14 Ms. James. But, Senator, we are not pushing anybody
15 out of the traditional system.
16 Senator Bradley. No.
17 Ms. James. We are offering this as an option.
18 Senator Bradley. Right. You are not pushing them out
19 of the system, you are simply saying, you can continue to
20 do what you want and pay more themselves, out of your
21 pocket.
22 Ms. James. If they choose one of the options in
23 Medicare Choice, then they pay the difference if the plan
24 costs more.
25 Senator Bradley. Right.

1 Ms. James. If they stay in traditional Medicare, it
2 is the same traditional Medicare program and there is
3 nothing that forces them out of the traditional Medicare
4 program.
5 Senator Bradley. But the other option has premiums
6 that are going up higher.
7 Ms. James. We are giving the beneficiaries are
8 choice.
9 Senator Bradley. Yes, but it is no choice. You are
10 basically saying, you can have a choice. You can stay in
11 Medicare and you will get a program where the Medicare
12 grant will not pay for your health coverage, so you have to
13 pay more than you are otherwise paying. That is what you
14 are telling them. You have that choice.
15 You can shop for a low-cost health care plan that will
16 not exceed the Medicare grant, and then you are fine. But
17 if you buy a more expensive health care plan or stay in a
18 fee-for-service and your premiums are higher, then you are
19 going to have to pay the difference between whatever the
20 Medicare grant is and whatever your cost is.
21 Ms. James. Senator, I think there is some confusion.
22 There is not a Medicare grant for every beneficiary. If
23 they stay in the traditional program, that does not apply.
24 Senator Bradley. But only if they go into an HMO,
25 right, or managed care program?

1 Ms. James. If they go into a private plan, there is
2 an amount of money made available to them and they can use
3 that amount of money and exercise whatever choice they want
4 of picking that type of plan. But if they stay in the
5 regular Medicare program, there is no amount or any
6 difference that they have to pay. It functions just as it
7 does today for Medicare beneficiaries.
8 Senator Bradley. Well, except you are cutting the
9 fee-for-service program dramatically. I mean, you can stay
10 in fee-for-service, but, by the way, we are putting in the
11 Belt Program, and by the way, we are doing this and that.
12 We are leaving the poorest, sickest in the program, so
13 obviously their costs are going to be more expensive.
14 To say, no, you have a choice, you can stay in fee-for-
15 service with poorer quality care or you can move into a
16 managed care system and probably pay a little bit more,
17 because the Medicare grant will not cover it, I mean, that
18 is not much of a choice.
19 Senator Rockefeller. And that is providing that the
20 providers are willing to see some of the seniors under the
21 new conditions which are contemplated.
22 Senator Bradley. That is right. You could very well
23 find providers saying, well, under this fee-for-service, we
24 are not going to take anybody on Medicare.
25 Senator Pryor. Mr. Chairman, could I join in here, or

1 is it someone else's turn?

2 The Chairman. Go ahead, David.

3 Senator Pryor. Are you sure? I do not want to take

4 someone else's turn.

5 The Chairman. No, no. You are next.

6 Senator Pryor. Thank you.

7 In this area that Senator Bradley has just been

8 discussing, and I understand Senator Graham asked a

9 question very similar to that that I am going to ask, but

10 I would like to approach it from a different way, in the

11 Medicare Choice program, what are going to be the new

12 standards? I am thinking of quality assurance.

13 At the Aging Committee last month, Senator Cohen,

14 myself, and others, held a hearing on quality assurance.

15 I came away from that session pretty disturbed about some

16 of the things that have gone on in the past about quality

17 assurance and HMOs. But I understand that, basically, the

18 plan that is now the Chairman's mark is sort of

19 restructuring the new standard.

20 I want to know, who is going to be the policeman and

21 which entity is going to be looking into the quality

22 control and quality assurance for those people that are

23 going to be induced or decide to make this new Medicare

24 Choice plan their plan?

25 Ms. James. Senator, we have essentially the same

1 standards on quality that currently apply to the Medicare
2 HMO program. We have made one change. There is no longer
3 a requirement that all plans contract with the peer review
4 organizations that are funded through the Medicare program.
5 We allow private organizations who are acknowledged by
6 the Secretary as doing a good job to be deemed as a private
7 organization and, therefore, they do not have to contract
8 with the pros.
9 But, otherwise, we do require the ongoing quality
10 assurance programs, we do require a grievance procedure, we
11 do require an appeals procedure. It is very similar to the
12 existing program, and it will be the responsibility of the
13 Secretary.
14 Senator Pryor. I thought also, on the appeals
15 procedure, that you sort of modified that. Are you keeping
16 the sale appeals procedure that we have now under present
17 law?
18 Ms. James. Yes.
19 Senator Pryor. And it would be appealed to the same
20 entity, I guess, as under present law. It would not be
21 appealed to HCFA under your proposal, would it?
22 Ms. James. Senator, it would be the same as we have
23 now.
24 Senator Pryor. The same as we have now. The appeals
25 process would not change.

1 Ms. James. Right. Right.

2 Senator Pryor. And these private organizations that
3 would be basically, I guess, policing and monitoring these
4 new HMO programs, is that a new creature or is that
5 something we are creating here?

6 Ms. James. Well, there are a number of organizations
7 that accredit health plans right now, that go in and look
8 at the kinds of procedures that they have, and there are
9 all sorts of quality indicators that they have. We assume
10 that there will be more interest if they are allowed to
11 develop programs that will go in and sort of put the Good
12 Housekeeping stamp of approval on a plan. It will still be
13 up to the Secretary to acknowledge whether that meets the
14 standards that are required.

15 Senator Pryor. Who will be responsible for making
16 absolutely certain that these new entities, these monitors,
17 will do their job right; will that be up to the Secretary
18 of HHS?

19 Ms. James. In order for the Secretary to recognize
20 these organizations and say that if you have a private
21 organization, do that, then the Secretary would recognize
22 that they do the adequate job.

23 We are just trying to eliminate a lot of duplication
24 right now, because a lot of employers require plans to have
25 all sorts of quality assurance mechanisms, and we do not

1 want to say that somebody over here is looking at the plan
2 and somebody over here is looking at the plan. If they are
3 looking at exactly the same things and there is an
4 acknowledgement that they are doing that, then we just want
5 to eliminate the duplication. Otherwise, the Secretary
6 would be responsible.
7 Senator Pryor. I just want us to be sensitive to the
8 concern that we may just be creating another bureaucracy
9 out there, except in the private sector, and eliminating,
10 maybe, a bureaucracy in the public sector. I do not know.
11 But I think that we have got to make certain that we are
12 going to have a net saving, a net efficiency, or something
13 is going to give better protection to those who move to the
14 HMOs for their medical and health care needs.
15 Ms. James. Yes, sir.
16 Senator Pryor. Thank you, Mr. Chairman.
17 The Chairman. Thank you.
18 Do you want to proceed, Julie?
19 Ms. James. If that concludes the questions on the
20 Medicare Choice program, we will move to the ----
21 Senator Graham. Mr. Chairman?
22 The Chairman. Yes.
23 Senator Graham. Could I ask a couple of follow-up
24 questions? You stated that your calculation of the savings
25 by virtue of increasing the percentage of persons in non-

1 fee-for-service from the 14 percent that is projected to a
2 range of 20-25 percent is $50 billion over seven years?
3 Ms. James. If you look on page two of the CBO chart,
4 the Medicare Choice program is scored as saving $46.5
5 billion over the seven-year period. It is the fourth line
6 down, on page two.
7 Senator Graham. Do you have a breakdown as to how
8 that number is arrived at?
9 Ms. James. I had lengthy discussions with the
10 Congressional Budget Office on this and they did not have
11 a breakdown for me.
12 Senator Graham. Could you provide that to us?
13 Ms. James. I will ask for it. Yes, sir.
14 Senator Graham. I am not familiar with this issue in
15 the proposal that is before us, but I understand that in
16 the House Medicare proposal if the targets for savings are
17 not met there is what is referred to as a look-back
18 procedure that would require some automatic reductions. Is
19 there a similar provision in this legislation?
20 Ms. James. We have a provision that we will be
21 describing on the subsequent walk-through that is a
22 backstop much like some of the fail-safe measures that were
23 in legislation last year. We do not achieve any savings
24 from this, it is simply a mechanism to make sure that you
25 do not exceed budget targets, and I will describe that as

1 we get to it. It is different, though, in approach.

2 Senator Graham. Thank you, Mr. Chairman.

3 The Chairman. Senator Rockefeller.

4 Senator Rockefeller. Mr. Chairman, just a quick one
5 on hospital, I have down hospital cuts, but you would say
6 hospital slowing of rate of growth, or whatever.

7 Under the Chairman's mark, disproportionate share
8 hospitals take, I believe, a 25 percent across the board,
9 I would say, cut.

10 Ms. James. A phase down.

11 Senator Rockefeller. Yes.

12 Now, PROPAC, and I have to read, now, in its March 1995
13 report said the following. "Many Medicare beneficiaries
14 rely on hospitals in underserved areas that furnish large
15 amounts of care to the poor and the uninsured. These
16 hospitals frequently have problems recruiting physicians
17 and other staff and meeting the special needs of their
18 patients.

19 Further, they tend to have a small share of privately-
20 insured patients, which limits their ability to subsidize
21 losses from Medicare, Medicaid, and the uninsured charity
22 care.

23 The extra revenue such hospitals receive from the
24 Medicare program through the disproportionate share payment
25 helps ensure reasonable access to care for beneficiaries in

1 unserved communities.

2 Reducing these payments to hospitals that are the only
3 source of care in a community without also expanding
4 coverage to the uninsured or otherwise subsidizing their
5 care will adversely affect their financial viability.
6 This, in turn, could threaten access for enrollees in
7 public programs. My only question is, what is the public
8 health policy rationale for that 25 percent across the
9 board cut in disproportionate share hospitals?

10 Ms. James. Senator, I do not know if you are aware,
11 we are going to be walking through all of the rest of the
12 Medicare package. We were just pausing at this point for
13 the Choice piece.

14 I just want to say, as far as on the Choice side in the
15 payment formula, we have taken the amount of payment right
16 now that goes to medical education and disproportionate
17 share spending in an area out of the payment base for
18 calculating the payments to the Choice plans, and we have
19 allowed then that the teaching centers and the hospitals
20 that have a lot of uncompensated care to get that money
21 directly from Medicare when they serve a health plan
22 patient.

23 The reason we made that policy change in developing the
24 payments was to make sure that the money in the Medicare
25 program that was intended to go for those purposes does,

1 indeed, go to those hospitals serving those patients. So
2 we are now talk about and go through the hospital things,
3 and will answer your question.
4 The Chairman. Senator Grassley?
5 Senator Grassley. I have several questions on the
6 Choice part. First of all, the extent to which you have a
7 very tough job in trying to work out the various sections
8 of the country, I acknowledge that, and think you have
9 worked extremely hard to do that.
10 My first question is probably simple. The way you
11 explained to us on Friday that the normalization process
12 would work, if nothing has changed dramatically from that,
13 then I do not need any explanation. If there have been any
14 changes over the weekend, then I would need to have those
15 explained to me.
16 Ms. James. There have not.
17 Senator Grassley. All right.
18 The second thing, on the very same point, before we
19 vote this bill out of committee will we be able to see from
20 you how you expect the various States to do under the
21 formula in the Medicare Choice plan?
22 Ms. James. Yes. I will have information that will be
23 available to all members at the end of the day.
24 Senator Grassley. All right.
25 The second point is, you have worked with a Physician

1 Payment Review Commission on this payment reform, as I
2 understand it, and you expect the transition period to
3 produce the results that you explained on Friday.
4 Will the legislation's instructions to the department
5 be specific and detailed enough to reliably produce the
6 results that you explained to us and that we can rightfully
7 expect.
8 In the sense of my opening comments, as you heard them,
9 we want to make sure that the legislation is written so
10 that the bureaucrats that administer the formulas and make
11 all the detailed interpretations and everything so that
12 what we say we want comes out the other end.
13 The question then is, is the language going to be
14 specific enough to produce the results we want?
15 Ms. James. Yes. The language will be specific on how
16 the payment is to be calculated.
17 Senator Grassley. A little more specific along the
18 same line, how much discretion will there be in the way
19 that the concepts in the legislation are interpreted by the
20 department. So you say the language is going to be
21 specific, but every statutory language has some leeway.
22 For the results you want, do you think that there is
23 any question that it is so complicated that maybe it will
24 not come out the way we wanted, or maybe you can say flat
25 out, it is so simple that it will come out with the results

1 that we want?

2 Ms. James. Senator, as you said, the Physician

3 Payment Review Commission has been assisting us in running

4 the numbers on our payment formula. We have also been

5 working with the Prospective Payment Assessment Commission.

6 These are the two commissions that advise Congress, and so

7 far their numbers look very similar.

8 I am sure that once the administration runs their

9 numbers we will see what they look like and will have some

10 idea of just what kinds of differences might arise, but we

11 expect that the language will be very specific so that it

12 will produce what we intend.

13 Senator Grassley. All right. Now, I am asking the

14 same thing another way. The extent to which there is some

15 discretion in the data used by the department to make

16 payment calculations, does this not give some leeway to the

17 bureaucracy so that we can have some question about whether

18 it comes out the way you say? And I am not questioning

19 your sincerity, we are dealing with data and there is some

20 discretion in that, as I would assume there would have to

21 be.

22 Ms. James. There will be some discretion, but we will

23 write it very specifically so that we know what the data is

24 that is going to be used in arriving at the calculations.

25 Senator Grassley. I do not want to mislead you. I

1 think that you are moving in the right direction. I hope
2 I complimented you in my opening statement. As we get into
3 this more deeply, I suppose that obviously, hopefully, we
4 will know more for certain in our own minds.
5 You have gone far enough in narrowing the per capita
6 rates and will satisfy us at this level, and then you are
7 trying to satisfy us that we will not be less happy with
8 what the department produced.
9 There is nothing in the mark which says, for instance,
10 that the variation from the low per capita payment to the
11 high per capita payment may be this percentage or that
12 percentage. Now, you have told us, I think it is in the
13 neighborhood of the mid-70s, right, the variation from the
14 low to the high?
15 Ms. James. I am sorry. Mid-70s in terms of?
16 Senator Grassley. Of the variation from the low cost
17 to the high cost.
18 Ms. James. In terms of dollar amount?
19 Senator Grassley. Yes.
20 Ms. James. Between top and bottom?
21 Senator Grassley. Yes.
22 Ms. James. No, Senator. I believe it will be a
23 little larger than that. I do not remember the 70s number;
24 I am sorry.
25 Senator Grassley. All right.

1 Ms. James. You are probably thinking about the
2 variation from the mean. We did use that figure.
3 Senator Grassley. All right.
4 Ms. James. And the simulations that we have right now
5 would narrow the current range, which is $500-600, down to
6 about $250 by the year 1998, and we have not gone beyond
7 that.
8 As you know, because of the concern about what will
9 actually happen with where we end up on the variation in
10 rates, we have included in the mark the language that has
11 the Secretary analyzing and reviewing and the opportunity
12 for Congress to act to change that.
13 Senator Grassley. All right. Then let me say this.
14 Let me not dispute whether it is this percentage or that
15 percentage, but you have done a good job of narrowing the
16 differential. All right.
17 Certain policy decisions went into narrowing that and
18 why it ought to be narrower rather than where it has
19 developed, into a wide deviation. Whatever you say would
20 be that deviation, and I would accept what you say, when we
21 pass the legislation, it seems to me that, three years down
22 the road, that ought to be the results we get.
23 Again, I am accepting your policy judgments, everything
24 that went into your thought process to bring us to a point
25 that we narrow the deviation, those are policy decisions,

1 and we assume that they are sound policy.

2 It seems to me we should not have any problem saying in
3 the legislation that this is what we wanted to accomplish
4 so that the bureaucracy, at the end of the three-year
5 period of time, has us where we say we want to be.

6 Ms. James. All right.

7 Senator Grassley. So I am suggesting that, because,
8 once again, I make the point that we have made mistakes in
9 this committee in the past, they have been particularly
10 harmful to the 32 States that fall below the medium cost of
11 the delivery of health care, and then we always try to fix
12 those mistakes.

13 We did not intend to do that, it just happened that
14 what we wrote could not be precisely followed and
15 consequently we ended up with something else. All right.
16 Just what you say we are going to accomplish, and intending
17 to accomplish, when we pass this legislation, I want to
18 know that that is the outcome three years down the road
19 when we have another review of this.

20 So I hope that is not a problem, because I just want to
21 say specifically in the language of the bill what you say
22 you hope to accomplish by the way you worked this formula
23 out for us based on the concerns that we all had.

24 On another point, I have a question about the
25 information provided to beneficiaries by the participating

1 health plans. This is question along the lines of
2 protecting consumers.
3 In the section dealing with the information which must
4 be provided beneficiaries who participate in the Medicare
5 Choice program, it states that, "the plans will be required
6 to describe the enrollee's rights to benefits and the
7 restriction on payment for services furnished by providers
8 other than those who participate in the plan."
9 Now, maybe the answer to this is that this is already
10 in the bill, but I could not find it. Should the plans not
11 have to describe any possible on restrictions on services
12 furnished through the plan, such as might occur through
13 pre-authorization review, concurrent review, post-service
14 review, or post-payment review?
15 Ms. James. The phrases that you used at the end are
16 not specifically in the mark in terms of the specificity of
17 having to indicate whether or not what kind of pre-
18 certification review, et cetera. But there is a
19 requirement that any restrictions on getting covered items
20 and services from the plan be described in the information
21 provided to the beneficiary.
22 Senator Grassley. All right.
23 Ms. James. I was not sure whether you were asking me
24 if that specific language was in there.
25 Senator Grassley. All right. Well, no. I think I am

1 more along the lines of, you understand what I want to
2 accomplish.
3 Ms. James. Yes.
4 Senator Grassley. You think that your legislation
5 accomplishes that.
6 Ms. James. Yes.
7 Senator Grassley. All right. What about any
8 financial incentive that might limit treatment or restrict
9 referrals such as economic profiling of providers,
10 capitation or other bonuses or set-asides which might be
11 furnished to the providers who meet spending goals
12 established by the plans?
13 Ms. James. That is not in there.
14 Senator Grassley. It is not in there. All right.
15 That is a concern of mine, but we will see what we can do
16 to deal with that.
17 What is your philosophical view about whether or not an
18 enrollee has the right to know if a provider faces economic
19 incentives which might affect their treatment decisions?
20 Ms. James. Well, I think an enrollee should be able
21 to ask that question and find out the answer. I think one
22 of the distinctions we are making here is how much
23 information will be provided routinely in the information
24 that is sent out. We do not want to be sending out
25 telephone books, but certainly if an enrollee wants any of

1 that information, they should have that information.

2 Senator Grassley. All right. Maybe the bill does not
3 provide for that, and we can do it in an efficient manner
4 so it does not lead us to the necessity to send out a
5 telephone book. I would like to have you look at that.

6 Ms. James. All right.

7 Senator Grassley. In regard to access to specialists,
8 now I am speaking about people who are specialists in the
9 sense of the training in that area and not somebody who has
10 been a resident on an oncology ward, we will say, for three
11 months and maybe had a little bit to deal with people that
12 had the problem with cancer, as an example.

13 Is there any provision in the bill which would require
14 a health plan to inform a prospective enrollee about the
15 types of providers, by specialty, who participate in the
16 plan?

17 Ms. James. Would each plan be required to list each
18 physician that participates? I am sorry. Is that what you
19 are asking, Senator?

20 Senator Grassley. Well, I do not want to talk in
21 terms of a person, a specific doctor, but I do want to talk
22 in terms of the type of providers by specialty that are
23 available through the plan.

24 Ms. James. Senator, I think that we can work together
25 to work this out in a way that assures beneficiaries the

1 right to access this information before they make their
2 decision.
3 I am not sure that we want to require that in whatever
4 is sent out across the Nation because there would be
5 different expectations in different geographic areas as to
6 the types of services that might be available, but I would
7 be happy to work to see if we could address your concerns
8 on that.
9 Senator Grassley. All right. This might be asking
10 the same question another way. But is there any provision
11 in the bill which would require a plan to make available an
12 appropriately trained specialist for health problems which
13 require the attention that that patient deserves?
14 Ms. James. Well, Senator, the plans are required to
15 provide for all of the services that are currently covered
16 under Medicare. So they are responsible to see that the
17 patients are served.
18 Senator Grassley. So you are implying, I think, that
19 that would be availability to specialists.
20 Ms. James. Yes.
21 Senator Grassley. On a very narrow issue, now, in my
22 State I have some people who are members of the Mennonite
23 Church.
24 Ms. James. Yes.
25 Senator Grassley. Could you tell me what changes you

1 see regarding the functions or operations of a preferred
2 provider organization which is an option for Medicare
3 beneficiaries enrolling in Medicare Choice? Specifically,
4 could you clarify what, if any, changes would be made to
5 the existing arrangements in PPOs between patients and
6 provider?

7 For instance, would PPOs be allowed to continue to
8 offer discounts to providers? Discounts are one of the
9 ways that the Mennonite populations have been able to make
10 arrangements through their own insurance organizations,
11 which might fall into the category, for instance, that you
12 have in for associations or unions, to get their plan
13 approved, to be able to provide discounts to providers, so
14 they can continue to use their present arrangements for the
15 delivery of health care to their members.

16 Ms. James. There is nothing in the plan that should
17 alter the way that their preferred provider organization
18 currently works. If they want to be a Medicare Choice plan
19 they would have to conform to the standards, they would
20 have to accept full risk, but there is nothing that would
21 affect their contracting with the PPO to provide those
22 services. So, we fully expect that some of the options
23 that will be offered in the plans will utilize preferred
24 provider organizations.

25 Senator Grassley. All right. For the same category

1 of constituents, it is the concern of some of the
2 Nationally-operated health plans that the geographic
3 boundaries which define Medicare Choice market areas would
4 create barriers or obstruct the current working
5 arrangements under which many of them operate. Again, that
6 would be the Mennonite Mutual Aid, as an example.
7 Can you, therefore, clarify what the relevance of a
8 Medicare market area will be to Nationally-operated plans
9 as union or association-sponsored plans, or rather can you
10 elaborate on the effects of the newly-formed local Medicare
11 Choice market areas to Nationally-operated plans.
12 Ms. James. Senator, we have defined payment areas
13 within the United States which reduce the current payment
14 from 3,100 counties down to about 300 some metropolitan
15 statistical areas and rural areas. Those are defined
16 primarily to determine what the payment amount is that will
17 be available to beneficiaries that live in that area.
18 We have also said that that can be considered the
19 service area. If a plan wants to cover that whole area,
20 then they do not have to go through an approval from the
21 Secretary.
22 However, we recognize that those payment areas do not
23 necessarily translate into service areas. So the Secretary
24 can determine what the service areas are for each plan and,
25 as long as there is no desire on the plan's part to try to

1 exclude certain populations or only serve certain areas, if
2 the Secretary determines that it is a reasonable service
3 area for the plan, then that can be accommodated.
4 Senator Grassley. Yes. Those are all my questions.
5 But, before I yield the floor I would just say to the
6 Chairman, thanks to him, because he included a concern that
7 I had about being locked in to a certain growth in this
8 program for the out years of the seven years, and
9 presumably well into the future.
10 And you have provided for a review of the formula and
11 the goals that we seek to accomplish, whether or not they
12 have been accomplished, and then what the growth should be
13 in the future in the various high-cost and low-cost
14 segments of the country to make sure that we do not get
15 ourselves down the road 10 years into the same vast
16 disparity of deviation between the high-cost State and the
17 low-cost States, or high-cost areas and the low-cost areas.
18 So, I thank the Chairman for his consideration of that
19 point of view. I think maybe three years after this very
20 dramatic change of Medicare it will not hurt to look at
21 this specific feature of it after a three-year period of
22 time as well.
23 Thank you, Mr. Chairman.
24 The Chairman. Thank you, Senator Grassley.
25 There will be a vote at 5:00, presumably, on a Mikulski

1 amendment to restore $425 million of spending for Americor.
2 Julie, I would like to ask you a couple of questions.
3 Is it not true that we have paid quite careful attention to
4 adverse selection issues with respect to the medical
5 savings account, and just what are those features?
6 Ms. James. We have paid careful attention to the
7 adverse selection for all of the plan options. We have
8 several in that. The enrollment is all done through the
9 Secretary and a plan has to take anyone, et cetera.
10 We have some additional safeguards on the medical
11 savings account option in that we require the one-year
12 notice prior to disenrollment so that you would be in the
13 plan for two years, and we feel that the medical savings
14 account option has a lot to offer to all beneficiaries, not
15 necessarily just sick beneficiaries; that with the $6,000
16 out-of-pocket limit on the plan, that that would appeal to
17 a lot of people; that sick people who need prescription
18 drugs that are not currently covered under the Medicare
19 program could use any additional money they might have in
20 their account for items like that. So, we feel that we
21 have addressed those issues.
22 The Chairman. Is it not true that CBO assumed that
23 there would be very little adverse effect on using the MSA
24 option in Medicare?
25 Ms. James. Yes. Yes, they did.

1 The Chairman. Do you want to proceed now?
2 Senator Breaux. Would the Chairman yield on that?
3 The Chairman. Yes.
4 Senator Breaux. That was one of the things that we
5 were talking about. What was your answer to the Chairman?
6 I am sorry. When he asked about, did CBO say there were no
7 adverse effects of proceeding to a medical savings account?
8 Ms. James. The Chairman asked me if there were very
9 little, and I said, yes. CBO indicated there was a small
10 effect.
11 Senator Breaux. How small?
12 Ms. James. Well, they didn't tell me. They just said
13 it was very small and it was difficult ----
14 Senator Breaux. Do you think it is a big small or a
15 little small?
16 Ms. James. I think it is a little small.
17 Senator Breaux. Little small. But you think that it
18 is a loss in revenues as opposed to a gain in revenues.
19 Ms. James. It was a small offset on the savings, yes.
20 Senator Breaux. Is that to say offset is the same as
21 a loss in this case?
22 Ms. James. Yes, Senator. This was a complex
23 provision to score. In talking to CBO, they were not
24 giving me these exact figures on how everything interacted
25 with each other.

1 Senator Breaux. That is one of the things, Mr.
2 Chairman. I mean, we can debate medical savings accounts,
3 but what we are doing is putting something into the plan
4 that we think is going to lose money. We do not know how
5 it is going to work. If we had one of those two we could
6 try it. If it is a big savings, let us try it. But here
7 it is, we know it is a loss. We do not know how much of a
8 loss and we do not know whether it is going to work.
9 Ms. James. We do know, Senator. I mean, we have
10 obviously discussed the whole issue of medical savings
11 accounts for several years. We do know that, if people
12 choose to manage their own care and take a high-deductible
13 plan, that they have less utilization than they would
14 otherwise.
15 This is an option that we feel should be made available
16 to Medicare beneficiaries, and we do not have any evidence
17 that would say that it would lose money or not. We do not
18 have any studies, so we just have to go with CBO's
19 estimates.
20 Senator Breaux. But you do have CBO's.
21 Ms. James. We do not have a detailed analysis with a
22 breakdown of what all the interactions are in the Medicare
23 Choice component of this bill.
24 Senator Graham. But you will have that. In response
25 to my earlier question, when you submit how the $47.5

1 billion of savings under Medicare Choice was arrived at,
2 that will include an analysis of the medical savings
3 account.
4 Ms. James. Yes, Senator. I will ask them for that.
5 The Chairman. Would you please proceed now, Julie?
6 Ms. James. Yes. I am going to turn it over to Susan,
7 now, who will begin talking about the provision that relate
8 primarily to Part A of the Medicare program.
9 Senator Moynihan. Before you do, could we hear once
10 again about that county in Texas with 141 persons?
11 Ms. James. Loving, Texas.
12 Senator Grassley. Mr. Chairman, before she leaves, on
13 Medicare Choice, could you tell me on what page in our
14 working document it is specific that a person can spend
15 their own money if they want to add to what the voucher is
16 to get into a Medicare Choice plan?
17 Ms. James. Well, on page 18, Senator, the next-to-
18 last paragraph says that, "payment for any premium amount
19 in excess of the Medicare payment amount that is due to the
20 Choice plan, the difference in premium is to be paid
21 directly by the beneficiary in the Choice plan, and there
22 is no limit on what that amount can be.
23 Senator Grassley. Is there anything in our bill that
24 allows an individual to put their own money, in addition to
25 the voucher, into the medical savings account?

1 Ms. James. No, Senator, because the way that the
2 medical savings account is constructed, since the interest
3 does not build up tax-free, there is not any incentive for
4 them to put it in that account. There is no tax incentive
5 to add their own money to it.
6 Senator Grassley. All right.
7 Do you figure, on the first point that I just raised,
8 that the marketplace will take care of everybody, knowing
9 that they will be able to add their money, or is that
10 something that should be put in the literature?
11 Ms. James. I think that the option will be described
12 in the information provided by the Secretary. Yes.
13 Senator Grassley. All right. Thank you.
14 Thank you, Mr. Chairman.
15 The Chairman. Susan?
16 Ms. Nestor. Thank you.
17 Senator Moynihan. And we are on page?
18 Ms. Nestor. I am going to cover pages 22-38,
19 primarily the hospital, nursing home, home care, and
20 hospice provisions. There will be a chart distributed to
21 you on the growth of spending in these programs as I am
22 doing the walk-through.
23 Starting on page 22, let me just say that Medicare pays
24 hospitals in four different ways, and I am going to talk
25 about provisions that relate to each of these areas. The

1 first of these areas relates to the annual inflation update
2 that the Medicare program provides to hospital; the second
3 relates to payments that Medicare makes for capital costs
4 of hospitals, that is, land, equipment, buildings; the
5 third, area of payments that Medicare makes to hospitals
6 are in a category of special payments to certain hospitals
7 that are teaching hospitals and hospitals that care for a
8 high portion of the poor. Finally, Medicare makes payments
9 to outpatient departments.
10 So starting on page 22, we have several provisions that
11 relate to the annual information update that Medicare pays
12 to hospitals. The present law in 1994 and 1994 was that
13 the annual inflation update is set at market basket minus
14 2.5 for urban hospitals, and we set an inflation update for
15 the rural hospitals that would allow their amounts to come
16 up to be the same as the urban hospitals. We paid a
17 differential until this year to urban and rural hospitals.
18 What we are suggesting in our proposal is, again, to
19 set the inflation update at market basket minus 2.5. And
20 let me say that market basket is a factor that measures the
21 prices that hospitals pay for goods and services. CBO
22 estimates that the hospital market basket runs just under
23 four percent, and so we are talking about that market
24 basket minus 2.5 percent each year for the next seven
25 years.

1 Senator Moynihan. Could I ask, Mr. Chairman, just
2 because it is just about usage that can be confusing or not
3 very clear, we are talking about it this morning in terms
4 of the consumer price index.
5 Ms. Nestor. Yes, sir.
6 Senator Moynihan. If you say, take it off, reduce it
7 by two percent, it does not sound like much. But if you
8 say two percentage points, it means you are cutting it by
9 two-thirds.
10 Ms. Nestor. That is correct.
11 Senator Moynihan. So, a market basket index minus
12 2.5 percentage points, which is what you are using right
13 here ----
14 Ms. Nestor. Yes, sir.
15 Senator Moynihan. What is that MBO running at, about?
16 Ms. Nestor. About four percent.
17 Senator Moynihan. So that is what I heard. So it
18 goes from four percent down to 1.5.
19 Ms. Nestor. Yes, sir.
20 Senator Moynihan. That is cutting it more than half.
21 Ms. Nestor. It is cutting the market basket. But, as
22 I mentioned, we have in historic years always sat the
23 inflation update at market basket minus an amount almost
24 every year.
25 Senator Moynihan. Yes. I am saying, that is not a

1 small reduction, it is a pretty big one.

2 Ms. Nestor. Yes, sir.

3 Senator Breaux. Can I ask a question at this point?

4 Ms. Nestor. Sure.

5 Senator Breaux. How does the CPI relate to the market

6 basket; is there no relationship?

7 Ms. Nestor. Senator, the CPI runs, generally, a

8 little bit lower than the market basket for hospitals.

9 When the take a look at the basket of goods and services

10 and products that hospitals have to buy, generally they

11 have found that those are a bit more expensive and so the

12 market basket has tended to run a little higher.

13 Senator Breaux. So a CPI adjustment would not affect

14 the market basket for hospitals and health care providers,

15 or does it?

16 Ms. Nestor. No, sir.

17 Senator Moynihan. Who computes the MBI?

18 Ms. Nestor. There is a research group--I am sorry, I

19 do not have the name with me--that the Secretary uses.

20 Senator Moynihan. He contracts it out.

21 Ms. Nestor. Yes, sir.

22 Senator Breaux. The American Hospital Association.

23 Ms. Nestor. No, sir. I know it is not that.

24 Senator Murkowski. Mr. Chairman, if I could follow

25 up.

1 The Chairman. Sure.

2 Senator Murkowski. Relative to the rural areas where
3 there is a cost of living allowance applicable, is there
4 consideration given to the market basket of CPI relative to
5 rural areas?

6 Ms. Nestor. Yes. The way that Medicare pays
7 hospitals has to do with a standard amount that we pay per
8 diagnosis, and then we also have another adjustment for
9 wages in different parts of the country. So, we do try to
10 take that into account.

11 Senator Murkowski. Do you have a chart of those areas
12 available?

13 Ms. Nestor. I do not have those with me. Those wage
14 adjustments are made on urban versus rural areas in the
15 country.

16 Senator Murkowski. Yes. But a rural area in Iowa is
17 a little different than a rural area in Northern Alaska.

18 Ms. Nestor. That is correct. I do not have those
19 with me, but I can provide those for you.

20 Senator Murkowski. I wonder if you could provide
21 those. I would appreciate it.

22 Ms. Nestor. Certainly.

23 Senator Murkowski. Thank you, Mr. Chairman.

24 Ms. Nestor. We also have a group of hospitals called
25 the Prospective Payment System Exempt Hospitals. We have

1 also recommended that we set the market basket for this
2 group of hospitals, which are the rehabilitation hospitals,
3 long-term care hospitals, cancer hospitals, at market
4 basket minus 2.5 percentage points for 1996 through 2002.
5 The second area of policy starts on page 24. This
6 relates to how Medicare pays for the costs of capital. We
7 have had in current law a requirement that each year the
8 Secretary make an adjustment so that the payments for
9 capital to hospitals, on an aggregate basis, will be 90
10 percent of what their reasonable costs of capital would be,
11 Medicare's share of that. That will expire this year if we
12 do not extend that in current law.
13 What we are suggesting is extending that and reducing
14 it another five percent, so we would ask that the Secretary
15 each year adjust the payments to be 85 percent of
16 reasonable costs for hospitals.
17 We also have the same provision for this special group
18 of hospitals that I have mentioned, the Prospective Payment
19 System Exempt Hospitals, the rehabilitation, long-term
20 care, and others.
21 Senator Breaux. Excuse me.
22 Ms. Nestor. Yes, sir.
23 Senator Breaux. Could you give us the savings on
24 market basket minus two percent over seven years? Is that,
25 what, 25?

1 Ms. Nestor. That is $36 billion.

2 Senator Breaux. $36 billion.

3 Ms. Nestor. Yes, sir. And that just relates to the
4 group of Prospective Payment System hospitals.

5 Senator Breaux. Yes.

6 Ms. Nestor. If I can move to hospital outpatient
7 department payments, the capital payments on page 25. We
8 also have the same provision for capital for the outpatient
9 departments that we do overall for hospitals, that is, that
10 the Secretary will pay 85 percent of their costs through
11 2002.

12 The second group of provisions on page 26 are the
13 special payments to hospitals, starting with payments to
14 disproportionate share hospitals. These are certain
15 hospitals in the country, about 2,000 hospitals of the
16 total 52,000 hospitals in the United States, that receive
17 a special adjustment from Medicare because they care for a
18 proportionately higher number of low-income patients. The
19 Medicare program recognizes that as an additional cost.

20 We have suggested that we set that payment amount to
21 equal, over the seven-year period, an average of five
22 percent of our Medicare prospective payment system
23 payments. This special payment, as a proportion of our
24 total payments, has grown from 1988 to two percent of those
25 payments to six percent of those payments.

1 Our provision would say that, on average, over the next
2 seven years we want those payments to represent about five
3 percent of prospective payment system payments. That
4 translates into a phasing down from current law spending of
5 about five percent a year over the next several years.
6 The second special payments that we make to hospitals
7 are to those hospitals that have teaching programs. We
8 have two special payments from the Medicare program that w
9 make to teaching hospitals.
10 The first payment is called direct medical education.
11 That payment is intended to cover the direct costs or
12 residents who are having their training experience in a
13 hospital. Post-medical school students go to hospitals for
14 their training. We have suggested in our proposal no
15 changes to the current payment system for direct medical
16 education.
17 The second special payment that the Medicare program
18 makes to hospitals is called an indirect medical education
19 payment. This payment is intended to cover the indirect
20 costs, such as teaching hospitals are believed to have more
21 complex patients, often because, particularly in large
22 teaching hospitals that have many residents training, they
23 are not able to be as productive because residents in
24 training may need to order more tests as they are going
25 through the learning experience.

1 We have a factor that we add to each discharge and pay
2 an extra payment. That is set today at 7.7 percent, and
3 what that means is, for a 100-bed hospital with 10
4 residents, we pay 7.7 percent more on each Medicare
5 discharge. We are suggesting phasing down that factor to
6 4.5 percent by the year 1998.
7 Senator Breaux. May I ask another question on that?
8 Do you do anything on indirect medical education to HMOs?
9 Ms. Nestor. In the Choice plans, what we have done,
10 the way the system works today, those costs are included in
11 the health plan payments. In our new program, we will take
12 those costs out and we will pay those directly to the
13 hospitals who see Medicare Choice patients, so they will
14 bill the Medicare program directly and we will pay them
15 directly for those costs.
16 Senator Breaux. So HMOs that are not doing teaching
17 would not be getting a higher reimbursement rate.
18 Ms. Nestor. That is correct.
19 Senator Breaux. All right.
20 Ms. Nestor. On page 28, there are several provisions
21 relating to the hospital outpatient departments. The first
22 has to do with, we want to fix the formula. We have a
23 formula today that Medicare uses to pay hospital outpatient
24 departments.
25 This is exactly the same provision that was in the

1 administration's plan last year. We have learned that this
2 mistake in the formula has been costing the program quite
3 a bit of money. We would like to get that fixed this year,
4 so we are proposing that we make the changes in the formula
5 that will make it work and take out the mistake.
6 Senator Grassley. Ms. Nestor.
7 Ms. Nestor. Yes.
8 Senator Grassley. I do not want you to explain what
9 the mistake was, we do not need to take the time to do
10 that.
11 Ms. Nestor. Right.
12 Senator Grassley. But is this an example of something
13 that the bureaucracy did not carry out Congressional
14 intent, or did Congress make the mistake?
15 Ms. Nestor. Senator, this was actually in the law
16 incorrectly.
17 Senator Grassley. So Congress made the mistake.
18 Ms. Nestor. I guess so. So we need to fix that.
19 Senator Grassley. We need to place the blame where
20 the blame is deserved.
21 Ms. Nestor. Yes.
22 The next hospital outpatient department payment
23 provision is to extend the current law provision. We
24 currently have a 5.8 percent reduction on hospital
25 outpatient department, the cost portion of those payments.

1 We suggest extending that through 2002.

2 The next provision relates to nursing home payments.

3 This is an area that I would just emphasize has been

4 growing very rapidly, particularly in the 1990s. Medicare

5 payments to nursing homes have gone up 35 percent a year

6 since 1990. We wanted to look very hard at our payment

7 system to see if there might be some ways that the payment

8 system was causing some of the increase in spending in this

9 area.

10 What we have found is that Medicare pays two ways to

11 nursing homes. We pay per day for the routine costs, that

12 is, the room and board costs and overhead, and then we pay

13 on a cost basis for everything else. That is primarily the

14 therapies, physical therapy, occupational therapy. That

15 seems to be the area that has been growing very rapidly.

16 What we are suggesting here is putting some limits on

17 the non-routine services payments from the Medicare

18 program. We will set those limits according to what a

19 nursing home's actual experience has been and a National

20 average amount.

21 The next provision relates to home health care

22 services. That starts on page 33. Let me just say that

23 this is another area that we looked very closely at,

24 because growth has been going up from 1990 to 1991, 44

25 percent, then 40 percent, then 35, then 22.

1 We also found in this area that Medicare pays per visit
2 based on the cost. What we are suggesting is a new payment
3 system where we would limit, according to the type of home
4 care patient, how much Medicare would pay.

5 We would set that according to the regional average and
6 home care agencies that can keep their costs down below
7 that and we would share in the savings with them. It is
8 moving us to a prospective system similar to the hospital
9 system payments that we have today.

10 Senator Pryor. Mr. Chairman, at that point, may I ask
11 a question, please?

12 The Chairman. Please do.

13 Senator Pryor. Has our vote started?

14 The Chairman. It looks to me like it has.

15 Senator Pryor. All right. I will just make this very
16 brief.

17 If we are going to allow some of the home health care
18 agencies to have a larger profit if they do not spend as
19 much per visit or per patient, if they spend below the
20 norm, is this not going to be an inducement for them to
21 spend less and to basically expend less care per patient so
22 they can have more profit?

23 Ms. Nestor. Senator, we have looked very closely at
24 that part of this provision and we are going to limit how
25 much the home care agencies can actually share in savings

1 so we do not get into that problem. We have also put in a
2 number of quality controls, particularly in the beginning
3 of this new payment system. This was one of the things we
4 were worried about when we started the prospective system
5 for hospitals.
6 We are going to monitor very closely patient needs and
7 what the home care companies are doing to make sure that
8 patients are getting the appropriate services, and we are
9 going to have to refine this as we go along. But we have
10 been working very hard on that this year.
11 Senator Pryor. Are you going to employ the same
12 monitoring, let us say, devices or entities that are now
13 being used, or are you going to create a new one?
14 Ms. Nestor. No. We would use the same devices that
15 are now currently available.
16 Senator Pryor. I see. Thank you.
17 Ms. Nestor. There is one more provision that I would
18 like to cover. This is payment for hospice services. This
19 is care for dying patients, on page 38. Medicare also has
20 an annual inflation update for hospice services. We are
21 recommending that we set the inflation update here exactly
22 the same as for other services, at market basket minus 2.5
23 percentage points for the next seven years.
24 I am finished.
25 The Chairman. This may be a good time to have a brief

1 recess so we can go and vote and return right back to
2 continue.
3 Senator Moynihan. Mr. Chairman, I believe Ms. Nestor
4 has finished her portion.
5 Ms. Nestor. Yes, sir; I have.
6 Senator Moynihan. I would like to express my, and I
7 am sure all of our, appreciation, for your clarity.
8 Ms. Nestor. Thank you.
9 Senator Moynihan. CBO gives you all the answers, and
10 they hardly give Julie any.
11 [Laughter]
12 Senator Breaux. I have one quick question. Did we do
13 skilled nursing facilities?
14 Ms. Nestor. Yes, sir; we did.
15 Senator Breaux. How much did you get out of that?
16 Ms. Nestor. Skilled nursing facilities, $10.4
17 billion.
18 Senator Pryor. Mr. Chairman, what are our plans for
19 the balance of the evening? I know we are not even halfway
20 through the walk through. Are we going to continue the
21 walk-through this evening?
22 The Chairman. Yes. It is my plan to return
23 immediately and continue until we finish.
24 Senator Pryor. We are going to jog through it, as
25 Senator Breaux says. Thank you.

1 The Chairman. The committee will be in recess for 10
2 minutes.
3 (Whereupon, at 5:21 p.m., the meeting was recessed.)
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 The Chairman. The Committee will come to order.
2 Julie, who is next?
3 Ms. James. We are going to move on to physicians,
4 and Alec will discuss this.
5 The Chairman. Alec?
6 Mr. Vachon. Thank you, Mr. Chairman.
7 I will first discuss the changes to physician
8 payments. In the area of physician payments, the
9 Chairman's Mark makes two changes: First, the Chairman's
10 Mark restores the integrity of the Medicare fee schedule
11 by combining three different payment rates currently
12 under Medicare, or conversion factors, into a single
13 conversion factor for 1996.
14 Because there are three different payment rates,
15 some physician services of the same relative value, and
16 which should be paid at the same amount of money, are
17 not. This change to a single conversion factor is
18 recommended by the Physician Payment Review Commission
19 and by most medical associations, as well as by the
20 Congressional Budget Office.
21 Second, the Chairman's Mark corrects technical
22 problems with the update formula, the formula which is
23 used to increase or decrease the fees Medicare pays to
24 physicians. The formula is used both to account for
25 inflation and to offset or increase, depending on how

1 well an expenditure target is met.
2 Over the past 2 years, however, the update formula
3 has given very large fee increases. For example,
4 surgical services in 1994-1995 combined have received a
5 22.2 percent fee increase. In the future, however, CBO
6 actually predicts negative updates. It is a highly
7 volatile system. The proposed formula revision in the
8 Chairman's Mark would lend less volatility to the current
9 system. It would also be based on a sustainable growth
10 rate of real GDP per capita, plus 2 percentage points.
11 Mr. Chairman, I will now move on to changes in
12 payment for clinical laboratories.
13 The Chairman. Could I ask a question. We were
14 talking about GDP being 4 points. Is that correct?
15 Ms. James. The nominal per-capita GDP is 4.3
16 percent.
17 The Chairman. So would that apply here?
18 Mr. Vachon. Yes. This is smaller, sir. I think
19 it is about 2.2 percent real GDP.
20 The Chairman. Two percent.
21 Mr. Vachon. Yes.
22 The Chairman. All right.
23 Mr. Vachon. Mr. Chairman. Next, in the area of
24 clinical laboratory fees, the Chairman's Mark would
25 continue a phased in reduction in lab fees begun with the

1 1993 reconciliation bill, and take those phased in
2 reductions one step further in 1997.
3 The Chairman's Mark also provides for no inflation
4 updates for laboratory fees from 1996 through 2002.
5 Mr. Chairman, next is durable medical equipment.
6 Durable medical equipment includes those items for use in
7 the home, such as wheelchairs and hospital-type beds.
8 Also included in the savings analysis are savings from
9 orthotics and prosthetics.
10 The Chairman's Mark would eliminate inflation
11 updates for most DME items for the next 7 years. The
12 Chairman's Mark would also cut prices of one category of
13 durable medical equipment, where there seems to be an
14 excessive payment rate.
15 In the area of ambulances, and ambulatory surgical
16 services, the Chairman's Mark provides for no inflation
17 updates for the period 1996 to 2002.
18 Mr. Chairman, next I will turn to the area of
19 increased beneficiary cost sharing. In the area of
20 increased beneficiary cost sharing, the intent was to
21 spread any additional beneficiary cost sharing over all
22 beneficiaries, rather than, say, adding or increasing
23 copayments that affect those individuals most using
24 medical services.
25 The first increased beneficiary contribution is in

1 the area of the Part B annual deductible, which is
2 currently $100. The annual Part B deductible would be
3 increased to $150 in 1996, and then increased annually by
4 $10.
5 I would note, Mr. Chairman, that in the 1990
6 reconciliation bill the Finance Committee and the full
7 Senate approved an increase of the deductible to $150.
8 The Senate, however, receded in conference.
9 In the area of the Part B premium, the monthly Part
10 B premium ----
11 The Chairman. What year was that you said?
12 Mr. Vachon. Nineteen ninety, sir.
13 The Chairman. Thank you.
14 Mr. Vachon. In the area of the Part B monthly
15 premium, the premium paid by all those enrolled in Part B
16 of the Medicare program, this year the Part B premium
17 covers 31.5 percent of Part B spending. The Chairman's
18 Mark would set this policy in statute for the next 7
19 years, and put into statute those premiums expected to
20 cover 31.5 percent of Part B spending.
21 One other provision, Mr. Chairman, is in the area of
22 the Medicare secondary payor. The Chairman's Mark makes
23 three changes to Medicare secondary payor policy. First,
24 the Chairman's Mark extends permanent law that Medicare
25 is a secondary payor for disabled beneficiaries. We have

1 employer-provided health insurance.

2 The Chairman's Mark makes permanent law and extends
3 to 30 months the period of time employer health insurance
4 is the primary payor for end-stage renal disease
5 beneficiaries.

6 And, last, the Chairman's Mark makes permanent a
7 data match program that allows the Medicare program to
8 identify when it should be the primary or secondary payor
9 for disabled, aged and ESRD beneficiaries.

10 Thank you, Mr. Chairman

11 The Chairman. Thank you, Alec.

12 Ms. James. Mr. Chairman, on page 43 ----

13 The Chairman. Yes.

14 Ms. James. ---- we have a provision which would
15 reduce the taxpayer subsidy for the Medicare Part B
16 premium. The beneficiary currently pays 31.5 percent of
17 Medicare Part B costs, and the additional 68.5 percent is
18 a subsidy from general fund revenues. This provision
19 would reduce, and gradually phase out that subsidy for
20 high-income individuals.

21 The thresholds are $75,000 of income for an
22 individual and $100,000 for couples. Those are the
23 thresholds at which the increased premium begins. At an
24 income level of $100,000 for singles and $150,000 for
25 couples, the beneficiaries would pay 100 percent of the

1 Part B premium.

2 This would be administered just as the current
3 premium is administered, by having the Social Security
4 Administration reduce the Social Security checks by the
5 amount of the premium.

6 Ms. Nestor. On page 46, we have a number of
7 provisions relating to rural health services, Senator.

8 The Chairman. All right.

9 But we do not have Senator Grassley here.

10 Ms. Nestor. I know. Senator Grassley and Senator
11 Pressler.

12 We are extending the Medicare-dependent hospital
13 program. These are special payments from Medicare for
14 hospitals with 100 or less beds and 60 percent of their
15 patients are Medicare patients. So these are small rural
16 hospitals that have a large number of Medicare patients.
17 And we are going to extend the special payments for these
18 hospitals.

19 Second, we are going to create a new limited
20 hospital program throughout the country. This will allow
21 small hospitals to transform, and not have to meet all
22 the Medicare requirements, such as having a 24-hour-a-day
23 emergency room in order to receive Medicare payment.
24 This will allow rural areas to have more flexibility by
25 taking small hospitals of 6 to 12 beds, and transform

1 them to better meet community needs.
2 We will also grandfather in a special program in
3 Montana that has been doing just, called the medical
4 assistance program, which allows small hospitals to
5 continue to receive Medicare payments.
6 The next program is a new program called the Rural
7 Emergency Access Hospital Program. Again, these are
8 Medicare payments to hospitals that are going to downsize
9 and essentially become small emergency rooms in rural
10 areas, where they will hold patients for 24 hours and
11 transfer them out to other areas.
12 We have two provisions that help expand primary care
13 in rural areas. We are going to have bonus payments
14 increase from 10 to 20 percent for primary care
15 physicians in health manpower shortage areas. And we
16 will now pay physician assistants and nurse practitioners
17 85 percent of the physician fee schedule in outpatient
18 settings.
19 Finally, we will have a new program for
20 telemedicine, which will allow us to explore ways that
21 rural physicians can use the telephone lines and
22 computers to serve patients and work with physicians in
23 other geographic areas.
24 The next area is a series of anti-fraud and abuse
25 provisions. We have several things we are doing in this

1 program. First of all, we will be establishing a
2 coordinated anti-fraud program. This will be jointly
3 established, and will also involve the Secretary of
4 Health and Human Services through the Office of the
5 Inspector General and the Attorney General. They will
6 jointly coordinate Federal, State and local law
7 enforcement activities, to combat fraud and abuse in the
8 Medicare and Medicaid programs.
9 Our provisions also include the establishment of a
10 mandatory account. The way the program will work is that
11 civil monetary penalties and other fines will flow into
12 the hospital insurance trust fund. The hospital
13 insurance trust fund will then fund an amount of money
14 each year that will then be used for all purposes
15 relating to our coordinated anti-fraud and abuse program.
16 We have a number of new guidelines. These are to
17 help providers understand the law, what is permitted and
18 not permitted relating to anti-fraud and abuse. These
19 are a number of expanded and clarified safe harbors,
20 interpretive rulings and special fraud alerts, which are
21 some communication devices with the providers to
22 understand the law.
23 We are also revising some of the current sanctions
24 for Medicare and Medicaid fraud and abuse, and
25 establishing some intermediate sanctions to give

1 providers an opportunity to put together a plan of action
2 before penalties apply.
3 We are also establishing a new data collection
4 program to share information in a data base, so that we
5 can become aware of some of the outrageous fraudulent
6 activities across the country.
7 We are increasing civil monetary penalties in a
8 number of areas, and have created a new section in the
9 Criminal Code for health care fraud and abuse.
10 We also are giving the State health care fraud units
11 a little expanded authority. When they are in the
12 process of looking and fraud and abuse in Medicaid, and
13 find it in our other Federal programs, we are allowing
14 them to help in those areas.
15 We have also added to the Chairman's Mark two
16 exceptions to the current anti-kickback statute. In the
17 areas of managed care and discounting, this would clarify
18 and allow certain exceptions to the anti-kickback law.
19 The Chairman. All right.
20 Senator Grassley. We are on fraud, Mr. Chairman?
21 The Chairman. Yes.
22 Senator Grassley. I think I have read the document
23 to my satisfaction that there is nothing in this that
24 changes the False Claims Act of 1986. That is a bill
25 which I sponsored, which lawyers call quitam legislation.

1 Ms. Nestor. Yes, sir. We do nothing to change
2 that.
3 Senator Grassley. Yes. I do want to point out to
4 everybody in the room, so it is you, Mr. Chairman, that
5 the House provision on anti-fraud strikes out, as far as
6 fraudulent use of taxpayers' money in health care
7 programs. It does not strike it out in Government
8 generally. But, in the health care programs, for any
9 organization that has a volunteer whistle-blower
10 provision within their organizations, if the whistle-
11 blower tells the management of the organization that
12 there has been certain fraudulent use of taxpayers'
13 money, then that triggers a situation where quitam
14 legislation could not be used.
15 We have had at least one suit of $110 million of
16 taxpayers' money that was recovered in the health care
17 area because of the quitam provisions.
18 If the House provision will prevail, every
19 organization related to health care is going to put in
20 some sort of volunteer whistle-blowing provision, which
21 then will preempt the quitam legislation.
22 I hope that people on this side of the Hill will
23 study the value of quitam legislation. This legislation
24 has brought $1 billion into the Federal Treasury, albeit
25 most of it from defense-related industry, and the defense

1 use of taxpayers' money. But there is plenty of
2 opportunity for the fraudulent use of taxpayers' money.
3 And we cannot expect every U.S. attorney to know where
4 the skeletons are buried, and in which closets.
5 Access and encouragement of whistle-blowing is going
6 to expose a massive waste of taxpayers' dollars. It is a
7 provision of the law that I think is proven. The $1
8 billion ought to prove that it has done some good that
9 otherwise would not have been recaptured. And I hope
10 that the Chairman will study this provision of law very
11 well. If it gets through the House of Representatives,
12 we will not agree to it in conference.
13 The Chairman. I know this has been an area of
14 special interest to the Senator from Iowa, and he has
15 done tremendous work in helping expose fraud and waste,
16 particularly in the Department of Defense. So I will
17 show him that, as we have worked together in the past in
18 many of these areas, I will work with him on that in the
19 future.
20 Senator Grassley. But in the area of detection of
21 health fraud, I could not hold a candle to the good work
22 you have done, even a long time before I ever came to the
23 Senate in this area. And I have worked very closely with
24 you, when you were Chairman of the Governmental Affairs
25 Committee, on legislation of this type. So I know that

1 you too have a concern and a track record in that area.
2 I was thinking that you may not have known of this
3 provision in the House bill, and I wanted to acquaint you
4 and everybody with it. Hopefully, we will keep the
5 present law, and not give an exemption to health care
6 organizations from the quitam legislation, and that we
7 will encourage whistle-blowing in any industry where
8 taxpayers' money is used. There are not enough U.S.
9 attorneys here to prosecute all this, and we need the
10 economic incentive of every citizen who knows about it.
11 If the Justice Department will not cooperate with a
12 whistle-blower to let the citizen move forward in court
13 to see that the issue is resolved, the taxpayers' money
14 recouped, and we get a sound use of taxpayers' money.
15 The Chairman. Well, as I indicated, I am very
16 sympathetic to the goals and objectives of what you are
17 discussing, and I will work with you as this legislation
18 progresses.
19 Ms. James. Mr. Chairman, if we can move to page
20 52, we have the budget expenditure limit tool. This is a
21 mechanism to assure that actual Medicare spending does
22 not exceed what we are projecting in this proposal. I
23 want to emphasize that this provision did not contribute
24 at all to the savings that were scored by CBO. There is
25 nothing in the $270 that is attributable to this

1 mechanism.

2 I would also like to point out that the figures in
3 the table on page 53 that indicate what the targets will
4 be, these will change until we get our final numbers on
5 the proposal. Then we will put in the final numbers.

6 The mechanism would work very similar to the Gramm-
7 Rudman-Hollings sequester mechanism. Basically, the
8 actual Medicare spending would be compared to the targets
9 and, if Medicare spending was exceeding what had been
10 projected, it would trigger a sequester, and there would
11 be a reduction in Medicare provider payments, in order to
12 make up for that overspending and get the program back on
13 track.

14 So it would be both a prospective and a
15 retrospective analysis of where the Medicare spending is,
16 in relation to where it was supposed to be. And there
17 would be a sufficient reduction in provider savings to
18 make up for that difference, so that the program would
19 get back on track, and we would not have a situation
20 where this entitlement program was growing much faster
21 than was envisioned.

22 Senator Moynihan. Could I ask Ms. James, Mr.
23 Chairman?

24 Ms. James. Yes.

25 Senator Moynihan. Ms. James, this is a tentative

1 table you have here?

2 Ms. James. Yes.

3 Senator Moynihan. And when do you think you will

4 get a table we would ----

5 Ms. James. Well, these figures, Senator, when we

6 are finished and know exactly. These are all preliminary

7 numbers. When we have our final numbers on this

8 legislation ----

9 Senator Moynihan. Then these come out.

10 Ms. James. Then these would become the targets for

11 the annual spending, yes.

12 Senator Moynihan. Thank you.

13 Ms. James. I would also mention that there is a

14 special provision in here, a special procedural

15 provision, that would allow Congress to have an expedited

16 procedure to intervene and make different reductions than

17 the reductions that would be called for in the mechanism.

18 The Chairman. All right.

19 Ms. James. Now, Senator, that concludes the items

20 that contribute ----

21 Senator Grassley. I have a question.

22 The Chairman. Yes, Senator Grassley.

23 Senator Grassley. We are at that point, right,

24 when we do not reach our budget figures, there will be a

25 sequester?

1 Ms. James. If the spending is exceeding what was
2 budgeted, yes.
3 Senator Grassley. Yes, all right.
4 If the spending overruns, would these spending
5 reductions called for in this section going to be
6 uniformly assessed across the country, regardless of
7 whether providers in particular market areas had not been
8 overspending? In other words, would providers in the
9 efficient low-spending areas have the suffer the same
10 spending reductions that providers in overspending areas
11 sustain?
12 Ms. James. The policies would apply nationwide,
13 uniformly.
14 Senator Grassley. All right. At this point, Mr.
15 Chairman, all I would do would be ask for consideration
16 of a point of view, because I do not think we have had in
17 any of our discussion in the past. We would have some
18 high-cost areas like Philadelphia, for instance, that
19 would spend $625 per person, per month--these are present
20 day figures--or Wayne, Michigan, with $567 a month. We
21 would have low-cost areas like Falls River, South Dakota
22 that would spend $177 per month, or Republic County,
23 Kansas would spend $230 per month, or Green County, Iowa
24 would spend $226.
25 All right. Of course, I need to say that associated

1 with the higher figures is sometimes a lot of
2 overutilization, highest number of doctors, more days
3 spent in the hospital, more access to specialists, and
4 things like this. In rural America, we might not have
5 these.
6 If you have a market situation in the high-cost
7 areas that encourages the overutilization of health care,
8 and we go over what is budgeted for the Medicare fee-for-
9 service system, it seems to me that if there are areas of
10 the United States that are more responsible for the
11 overutilization and increased costs than other sections
12 of the country, we are only going to encourage those
13 high-cost areas to be less conservative, less
14 responsible, if they do not suffer any more of a penalty
15 that low-cost parts of the country do.
16 And when you have this uniform assessment across the
17 country of a reduction, that is exactly what is going to
18 happen.
19 Now I am not prepared to say what we should do about
20 that, but I think that is a consideration. If we are
21 going to try to get more responsible use of the delivery
22 of medical care, and more of that comes in the high-cost
23 areas than in the low-cost areas, then we should not
24 encourage that, and we surely should not penalize
25 conservative parts of the country that are not a part of

1 the problem.

2 I just throw that out for your consideration. You

3 do not even need to comment now. We will talk about it

4 later.

5 The Chairman. All right. Shall we proceed?

6 Ms. James. Mr. Chairman, that concludes the

7 provisions in this proposal that went towards arriving at

8 our $270 billion figure. I actually should have said

9 this before I discussed the budget expenditure limitation

10 tool, but we have two more provisions.

11 These two provisions were includes solely to address

12 the problem of the solvency of the Medicare trust fund.

13 The first one on page 54 is conforming the eligibility

14 age for Medicare to the eligibility age for Social

15 Security. We now have a phase-in, beginning in the year

16 2003, where the eligibility age increases by 2 months,

17 and then phases up to the year 2027, I believe, where the

18 eligibility age would be 67.

19 The Chairman. So it takes 24 years to phase in the

20 2-year increase.

21 Ms. James. Yes. And it conforms to the present

22 law for Social Security.

23 The second provision is extending the hospital

24 insurance tax to all State and local government

25 employees. Some State and local government employees

1 that were hired before April 1, 1986 do not currently pay
2 the HI tax. This provision would require all of these
3 employees to pay it. We know that about 98 percent of
4 these employees end up getting Medicare coverage, either
5 through other employment or through their spouses. So
6 this would equalize that and contribute to the long-term
7 solvency of the trust fund.
8 The Chairman. All right.
9 Ms. James. Mr. Chairman, that is the end of the
10 Medicare portion.
11 Senator Moynihan. I guess we will want to have
12 estimates on how much we would raise by extending.
13 Ms. James. I have that estimate, Senator.
14 Senator Moynihan. Oh, good. Wow. Here we have an
15 efficient staff.
16 Ms. James. I have that one. I believe it is $13.5
17 billion over the 7-year period.
18 Senator Moynihan. Well, do you not include that in
19 your revenue estimates? That is sizeable amount.
20 Ms. James. No. We do not have any revenue
21 estimates in this. These are just reduced spending.
22 Senator Moynihan. Oh, that is included in you
23 reduction.
24 Ms. James. No. That money is not included in the
25 money we are saving, in our instructions for saving $270

1 billion.

2 Senator Moynihan. Oh, I see. This comes under the

3 heading of revenue.

4 Ms. James. Exactly.

5 The Chairman. And that does not count.

6 Senator Moynihan. Thirteen and a half billion. We

7 had that one last year.

8 The Chairman. Thank you Julie, and Susan and Alec,

9 very much.

10 I guess we now turn to you, Roy, on Medicaid.

11 Mr. Ramthun. Mr. Chairman, the Medicaid proposal

12 in the Chairman's Mark begins on page 56.

13 Mr. Chairman, the Medicaid proposal is unchanged

14 from the initial release of the Chairman's Mark. So I

15 will just hit some of the highlights to reacquaint

16 Members with the Medicaid proposal.

17 The Medicaid program would remain a program for low-

18 income families and individuals in this country.

19 However, States would be given much greater flexibility

20 to determine who is eligible, and kinds of benefits that

21 they provide to those individuals.

22 States would be required to meet certain minimum

23 spending obligations for three specific groups of

24 beneficiaries with low incomes. The three groups are

25 families with a pregnant woman or a child, elderly

1 individuals, and disabled individuals.

2 The amount that the State would be required to spend
3 would be on a percentage basis, not a dollar basis. The
4 percentage would be equal to 85 percent of the State's
5 former percentage of spending on each of those groups for
6 those individuals the States were required to cover, and
7 for the services they were required to provide to those
8 individuals.

9 States would have much greater flexibility in
10 setting payment rates to providers, as well as
11 determining provider qualifications. The Boren
12 amendment, which is a provision of current law which
13 governs reimbursement for hospitals and nursing homes,
14 would be repealed, as well as would cost-based
15 reimbursement requirements, which would also be repealed.

16 As you may recall, these two provisions are also
17 included in President Clinton's June budget proposal for
18 Medicaid.

19 States would determine their provider standards, be
20 they in the fee-for-service sector or for managed care.
21 States would no longer be required to seek waivers from
22 the Federal Government to enroll beneficiaries in managed
23 care programs, or to put elderly and disabled individuals
24 into home- and community-based care programs as an
25 alternative to being institutionalized in a nursing home.

1 We would replace the Federal minimum nursing home
2 standards that are currently in both the Medicare and
3 Medicaid laws with a new set of standards in only the
4 Medicaid law. This would essentially replace the Federal
5 standards with a set of State standards that are very
6 similar to the current law requirements.
7 I would underscore that the Federal nursing home
8 standards for the Medicare program are not being affected
9 here. They will still remain in place. It is my
10 understanding that roughly 61 percent of nursing homes in
11 this country participate in both Medicare and Medicaid.
12 In order to do so, they would continue to have to meet
13 the Medicare standards, if anyone thought the State
14 standards would be less than the current law standards.
15 The standards would also apply to the protection of
16 residents' rights, which have been written into the law.
17 States would have to have a certification program to
18 assure the quality of care that is provided in nursing
19 homes. When States find deficiencies in nursing homes,
20 they would be required to sanction them, and make the
21 evaluations of the nursing homes available to the public.
22 The Federal Medicaid drug rebate program, which has
23 been in existence since 1990, would remain in effect, but
24 would be terminated effective October 1, 1998.
25 The Chairman's Mark would remove disproportionate

1 share hospital funding from the current Medicaid base,
2 reduce it to a level of $5 billion, which compares to the
3 present level of $8.5 billion, the Federal share. This
4 money would be targeted to hospitals that meet specific
5 criteria of need. The need would be defined as the
6 proportion of Medicaid and uninsured patients that they
7 are serving in those areas.
8 The money would be paid directly from the Secretary
9 to those hospitals, would not go through the State. The
10 criteria by which hospitals qualify for these targeted
11 DSH funds would be similar to the minimum Federal
12 standards that are in current law today.
13 Federal funding in the future for the Medicaid
14 program would be limited on an aggregate basis. Each
15 State would have an aggregate cap placed on the amount of
16 Federal funding it could receive from the Federal
17 Government. States would have to put up State dollars to
18 receive Federal matching dollars, as they do under the
19 existing program. However, there would be an outer limit
20 on the amount of Federal funding that each State could
21 receive.
22 I regret to inform you that we still do not have the
23 formula for the distribution of funding across the States
24 worked out. We are very close. We should have that
25 either later this evening or first thing in the morning.

1 I would be happy to go into more detail to describe how
2 the formula would work, how much the States would get,
3 and explain the rationale behind the proposal when we
4 have that finished.
5 Senator Moynihan. That is the counterpart to the
6 House of Representatives' proposal?
7 Mr. Ramthun. Yes.
8 Senator Moynihan. Six percent, 4 percent, 2
9 percent.
10 Mr. Ramthun. States would still be held
11 accountable for their expenditures of Medicaid funds. We
12 would have provisions in place to make sure that States
13 do not use the Federal funds to provide other than health
14 care services to low-income individuals. We would
15 require States to continue to report annually to us the
16 data on their expenditures, and their services provided
17 to individuals who are low-income in their State.
18 States would be required to go through a public
19 process in developing a State plan, which is a public
20 document describing all the details of the State's
21 decisions to determine who they make eligible under the
22 program, the types of benefits they provide them, and the
23 types of services that are available to them.
24 The Secretary would still conduct oversight. We
25 have worked very closely with the Governors to try to

1 reduce some of the antagonistic relationship that
2 currently exists, and try to make it a situation that is
3 a little bit more conducive to working out the
4 differences between the State and Federal Government,
5 instead of going into dispute all the time.
6 Those are the major highlights of the Medicaid
7 provisions in the Chairman's Mark.
8 Senator Moynihan. Mr. Chairman, it was remarked
9 this morning that current Medicaid outlays are rising at
10 10.5 percent, and I take it that the purpose is to reduce
11 this in half to 5 percent.
12 Mr. Ramthun. Yes, that is correct.
13 The Chairman. Any more questions?
14 Senator Moynihan. We will have questions tomorrow,
15 but we want to hear the formula.
16 The Chairman. All right. Does that finish your
17 section, Roy?
18 Mr. Ramthun. Yes, Mr. Chairman. That concludes
19 the discussion of Medicaid.
20 The Chairman. Brig, are you going to do EITC?
21 Ms. Gulya. Yes, sir.
22 Senator Grassley. I have some questions on
23 Medicaid.
24 The Chairman. All right. Please proceed.
25 Senator Grassley. I think I have three questions,

1 pretty narrowly focused, Roy.

2 I am looking at how the current Medicaid rule would
3 affect veterans' homes. I think about 20 States have
4 veterans' homes. Mine is one of those. Initially,
5 veterans residing in veterans' homes paid all but $90 of
6 the veteran's pension to the home to help with the cost
7 of their care.

8 A recent court ruling now allows Medicaid-eligible
9 veterans to keep their entire pension, making Medicaid
10 pay the entire cost of their care. Other veterans must
11 still spend down their pensions to $90. This obviously
12 appears to be an unfair situation. In any case, would
13 you clarify how this Federal Medicaid requirement would
14 work in the event that this Medicaid proposal is enacted?

15 Mr. Ramthun. I am not quite sure how it would work
16 in this situation. I believe that under the Chairman's
17 Mark, the State would have the ability to try to access
18 those veterans' pension funds, but I think it would
19 require a specific change in Federal law which would make
20 that change mandatory.

21 The question would be whether we would want to
22 impose such a requirement on the States, or to allow them
23 some ability to access those pension funds. It may
24 require some change in the veterans laws to specifically
25 allow States to gain access to those pension funds. We

1 have been trying to sort this issue out for a couple of
2 months.
3 Senator Grassley. And it is too sticky of a
4 situation to deal with, or too complicated to deal with?
5 Mr. Ramthun. It is a very complicated issue.
6 Senator Grassley. All right.
7 On another question, does the set aside for the
8 elderly include 85 percent of the amount of funds that
9 Stats spent on Medicare premiums for qualified Medicare
10 beneficiaries? And will the States be asked to spend
11 that amount on Medicare premiums or any other cost-
12 sharing?
13 Mr. Ramthun. You are correct that the current
14 spending on Medicare premiums, as well as out-of-pocket
15 expenses, the Medicare cost-sharing for those
16 individuals, that Medicaid does pick that up, is in the
17 calculation of the set aside percentage for the elderly
18 population. There is no specific requirement on States
19 that they continue to pay those premiums. Frankly, I
20 believe it is in States' interest to make sure that they
21 pay those premiums so that those individuals are enrolled
22 on Medicare, and Medicare will pick up the great bulk of
23 their acute care expenses.
24 Senator Grassley. All right. Now, once again, on
25 just a little different point about this 85 percent in

1 the three areas--families with pregnant women and
2 children, elderly individuals, disabled individuals--
3 where the State has to spend 85 percent of the average
4 percentage of the State's Medicaid spending during fiscal
5 year 1992 and 1994 for mandatory services for members of
6 those groups who were required to be covered under the
7 current Medicaid law.
8 Because the long-term care services for people with
9 mental retardation and other developmental disabilities
10 are optional under current law, could you clarify if it
11 is the intent of this legislation to no longer obligate
12 the States to continue to spend Medicaid dollars on long-
13 term care for people with mental retardation or
14 disabilities?
15 Mr. Ramthun. I know that the nursing home
16 expenditures are in the elderly calculation for the set
17 aside. I will have to double check on whether the
18 institutions for the mentally retarded are in the
19 disabled set aside calculation. I do not remember off
20 the top of my head.
21 Senator Grassley. If I indicated that I was just
22 talking about institutions, the answer would be that I am
23 not. I would be talking about groups homes as well,
24 smaller community-based facilities. Or were you thinking
25 about that when you used the word institution?

1 Mr. Ramthun. I was thinking of the nursing homes
2 for the mentally retarded, not the community-based.
3 Senator Grassley. Yes. Well, I would be speaking
4 of the community-based ones, maybe even more so than the
5 institutions because, you know, there is such a movement
6 away from State institutions now to the community-based
7 facilities. I do not know whether that would still be an
8 issue, but that is not my main issue.
9 Mr. Ramthun. Well, remember that we are just
10 looking at the amount of spending on proportional basis
11 that the State was spending in previous years.
12 Certainly, the nursing home care for the mentally
13 retarded is the most expensive that the disabled mentally
14 retarded receive today. And that provision is the one
15 that I am not sure is in the calculation. As I look back
16 into the document, I believe it is not in the
17 calculation.
18 So there would be no specific institutional
19 services, unless they are considered nursing home
20 services, that the individual is receiving. The specific
21 class of institutions specifically for the mentally
22 retarded, as well as the community-based programs, would
23 not be part of the calculation of the set aside for the
24 disabled.
25 Senator Grassley. The 85 percent, then, is just

1 based upon the mandatory services, or would it based upon
2 the mandatory services plus the optionals?
3 Mr. Ramthun. It is just the mandatory services.
4 The optional services are not part of the calculation.
5 Senator Grassley. Thank you.
6 The Chairman. Brig, do you want to proceed now?
7 Senator Moynihan. Mr. Chairman, if I could just
8 say, if we are going to move to the earned income tax
9 credit, could I ask that Secretary Samuels be available
10 at the desk for purposes of questioning?
11 The Chairman. Yes.
12 Senator Breaux. Could I ask you a question on
13 Medicaid before we go ahead?
14 The Chairman. Yes.
15 Senator Breaux. On the vaccines for children
16 program under Medicaid, I take it that this proposal
17 terminates it as a program, but how does it address it
18 under the mandatory requirements that States have some
19 things that I think are still mandatory under the block
20 grant? Are vaccines included in that? I think States
21 are still required to immunize children.
22 Mr. Ramthun. States are still required to immunize
23 children under the Chairman's Mark. There may be
24 vaccines being provided under the Early Periodic
25 Screening, Diagnosis and Treatment services, which are a

1 mandatory service under current law. There is no
2 specific current law service which says immunization, so
3 some of them may be in that category. Some of them could
4 possibly be covered under a physician service. It
5 depends upon whether the physician bills separately for
6 the vaccine itself. Certainly there would be an office
7 visit involved.
8 In addition, there is mandatory coverage of rural
9 health clinic services and Federally qualified health
10 center services. Those types of services do not
11 distinguish between the actual service provided. Each
12 visit that an individual makes to one of those clinics
13 would be counted as a service. So those are examples of
14 how vaccines might currently be part of the set aside
15 calculation. But, other than that, there is no specific
16 immunization piece in the set aside calculation.
17 However, there is the requirement on States to immunize
18 the children.
19 Senator Breaux. I am concerned, and I would like
20 to ask another question about the inability of the States
21 to buy in bulk rates to get better prices for vaccines.
22 Under this block grant program, if the State wanted to,
23 could they use a portion of their block grant money to
24 buy vaccines, say from the Centers for Disease Control,
25 at a bulk rate because they buy in volume? Would they be

1 allowed to do that?

2 Mr. Ramthun. I believe purchase of vaccines would

3 be an allowable expense under the Medicaid program. I do

4 want to emphasize that we are in no way repealing the

5 Public Health Service programs, the 317 program, through

6 which the Centers for Disease Control negotiate contracts

7 to purchase vaccines for the public health clinics around

8 the country. There are a dozen States who exercise an

9 option under that program, to purchase vaccines for all

10 the children in their State. We are not affecting that

11 program at all, so they could have several options here.

12 Senator Breaux. All right. Thank you.

13 Thank you, Mr. Chairman.

14 The Chairman. Thank you, Senator Breaux.

15 Brig?

16 Ms. Gulya. Discussion of the earned income tax

17 credit reform proposal begins on page 77 of the

18 Chairman's Mark.

19 In brief, under present law, the earned income tax

20 credit was first added to the Internal Revenue Code as a

21 temporary measure in 1975, to provide cash assistance to

22 low-income working families with minor children. It was

23 made permanent in 1978, and has been expanded several

24 times over the years.

25 The annual cost of the EITC has increased

1 substantially. During its initial 10 years, the annual
2 cost roughly doubled, rising from $1.3 billion in 1975 to
3 $2.1 billion in 1985.
4 During the past 10 years, the cost of the EITC rose
5 from $2.1 billion in 1985 to almost $20 billion in 1995.
6 By the year 2002, the EITC is expected to rise to almost
7 $32 billion.
8 The EITC is a refundable tax credit, meaning that it
9 first offsets any income taxes owed by an individual, and
10 then the remaining EITC is paid by check to that
11 individual from the Federal Government.
12 The amount of the EITC received by a taxpayer
13 depends on whether they have one, more than one, or no
14 qualifying children, and is determined by multiplying the
15 applicable credit rate by the taxpayer's earned income,
16 up to a maximum earned income amount.
17 The EITC is phased out at certain income levels, and
18 is reduced by a phase-out rate that is multiplied by the
19 amount of the earned income, or AGI, adjusted gross
20 income if greater, in excess of the beginning phase-out
21 income amount.
22 For those with earned income, or adjusted gross
23 income if greater, in excess of the ending phase-out
24 income amount, no credit is allowed. The maximum earned
25 income amount and the beginning phase-out income amount

1 are both indexed for inflation. The ending phase-out
2 amount also rises if there is inflation.
3 I will now turn to our reform proposals. The first
4 piece of our reform proposal involves individuals who are
5 not authorized to be employed in the United States. Only
6 individuals who are eligible to work in the United States
7 would be eligible to receive the earned income tax
8 credit. Taxpayers claiming the EITC would be required to
9 provide a valid Social Security number for themselves
10 and, if married, their spouse's taxpayer identification
11 number and that for their qualifying children.
12 Social Security numbers would have to be valid for
13 employment purposes in the United States, and taxpayers
14 residing illegally in the United States would no longer
15 be eligible to receive the EITC.
16 An additional proposal which we have to get to
17 compliance issues would allow the Internal Revenue
18 Service to use simpler procedures to resolve questions
19 about questionable Social Security numbers. These
20 procedures would also be allowed to the IRS in cases
21 where taxpayers claim the EITC, and fail to pay their
22 self-employment taxes.
23 The proposal would help insure that only legitimate
24 EITC claims are processed.
25 The second part of our proposals would repeal the

1 EITC for individuals without qualifying children. The
2 EITC would no longer be available for individuals without
3 qualifying children, and this change would help refocus
4 the EITC program on low-income working families. This
5 would help return the program to its original purpose,
6 which was helping families with low income and children.
7 The next piece of our proposal would maintain the
8 credit rate for individuals with two or more qualifying
9 children at 1995 levels, which would mean a 36 percent
10 credit rate.
11 We would also change the definition of disqualified
12 income. The wealth test, as it is known, was enacted
13 just earlier this year, in an effort to ensure that
14 people who claim the EITC because of low earnings would
15 no longer be able to do so if they had substantial
16 financial assets.
17 Our definition of disqualified income would be
18 expanded to look at a person's net capital gain income
19 and passive income.
20 The next piece of our proposal would change the way
21 the EITC is phased out. Rather than specifying a phase-
22 out rate, the EITC would be phased out over fixed dollar
23 income ranges. The amount of earned income tax credit
24 that may claimed by a taxpayer would be reduced by a
25 certain percentage by each $100 or portion thereof, by

1 which the taxpayer's earned income exceeds the applicable
2 phase-out amount.
3 For taxpayers with one qualifying child, this
4 percentage would be 0.82 percent, meaning that the EITC
5 would be phased out over an income range of $12,100. For
6 taxpayers with more than one qualifying child, the
7 applicable percentage would be 0.62 percent, meaning that
8 the EITC would be phased out over an income range of
9 $16,100.
10 The income amounts at which the EITC phase-out
11 begins would continue to be indexed for inflation, and
12 this phase-out income range will also help re-target the
13 EITC program to low-income working families.
14 An additional aspect of our modification of adjusted
15 gross income used for phasing out the credit would have
16 two pieces to it. Certain items would be added to AGI
17 for purposes of determining eligibility for the earned
18 income tax credit. These items would be tax-exempt
19 interest, Social Security benefits that are not subject
20 to income tax, non-taxable distributions from pensions,
21 annuities and IRA's, and child support that is received.
22 The following items would be excluded.
23 Senator Breaux. Pardon me.
24 Ms. Gulya. Yes, sir.
25 Senator Breaux. So you are going to count as

1 income these four items that are not now being counted?

2 Ms. Gulya. Yes.

3 Senator Breaux. What is number 2?

4 Ms. Gulya. Number 2 is Social Security benefits

5 that are non-taxable.

6 Senator Breaux. Which ones are they?

7 Ms. Gulya. Certain payments made under the Social

8 Security program are not subject to tax.

9 Senator Breaux. I know. Which ones?

10 Ms. Gulya. Excuse me a second.

11 [Pause]

12 Certain disability benefits are non-taxable.

13 Senator Breaux. So we are going to start counting

14 Social Security disability payments as income for people

15 who are already poor?

16 Ms. Gulya. The one thing to remember about this

17 aspect ----

18 Senator Breaux. I am just trying to find out what

19 Social Security benefits not subject to income tax for

20 the first time will be counted as income under this

21 proposal for people on the EITC.

22 Ms. Gulya. All right. For purposes of this

23 program, in determining eligibility, we will be looking

24 at Social Security benefits that people receive if they

25 are disabled or if you have grandparents, for example,

1 taking care of children as well.

2 Senator Breaux. How about widowed folks? Are
3 their Social Security payments counted as income now?

4 The Chairman. I invite Mr. Kies to come forward.

5 Senator Breaux. Yes. Maybe we can get Mr. Samuels
6 to comment too. I am just trying to find out what we are
7 saying is going to be income that is not now counted as
8 income.

9 Mr. Kies. There are a number of portions of Social
10 Security benefits that are not currently taxable. Only a
11 portion of the regular Social Security beneficiaries'
12 benefits are taxable under the various provisions that
13 have been enacted, and which were changed in 1993. So
14 that portion of just regular Social Security benefits
15 would be added to AGI, even though they are not generally
16 taxable, for purposes of determining whether or not a
17 taxpayer is subject to this phase-out.

18 There are certain Social Security disability
19 payments which are not taxable under current law either.
20 Those would be added. They would not be made subject to
21 income tax; they would only be included in the measure of
22 income to determine whether a taxpayer is subject to the
23 phase-out.

24 Senator Breaux. I understand that.

25 So you are picking up Social Security payments to

1 disabled people, and counting that as income for
2 determining whether they can get an EITC. Any other
3 group that is exempt? How about retirees? So it is
4 retired and disabled people. How about widowed people?
5 Mr. Kies. Anyone who is receiving EITC. It could
6 include a widow who is receiving Social Security
7 payments.
8 For example, there are some grandparents who are
9 taking care of children, so it is their dependent. But,
10 again, it is only for purposes of determining whether or
11 not the individual has an amount of income that is
12 greater than the amount for determining whether or not
13 they are eligible for the earned income tax credit.
14 Senator Breaux. What kind of an increase or loss
15 of benefits would this mean to disabled people?
16 Mr. Samuels, do you have any comment?
17 Mr. Samuels. Senator Breaux, I just want to
18 confirm that it is also our understanding, as Mr. Kies
19 described, that the types of Social Security payments
20 would be included in income for purposes of determining
21 the phase-out of the EITC.
22 We estimate that the taxpayers who would be affected
23 by this would have, on average, adjusted gross income of
24 about $9,500. So that is the group who would be
25 affected. They are earning about $9,500, and also

1 receiving Social Security. So a family where, say, a
2 husband is disabled and receiving disability benefits,
3 and the wife is working, they have two children, their
4 EITC would be phased out because the disability benefits
5 would be included in income.

6 From our perspective, it has the effect of taxing
7 those Social Security benefits because, in the absence of
8 this provision, they would otherwise have received the
9 earned income tax credit.

10 Senator Breaux. Mr. Chairman, I cannot imagine how
11 we can make adjustments in the EITC. We will argue the
12 merits later. But to all of a sudden start taxing the
13 disability payments for people who are making $9,500 a
14 year, to count that and knock them out of the program, I
15 think is very unwise.

16 What about the child support received? What does
17 that mean. As I understand it, child support is not now
18 taxable to a mother in most cases. If the former husband
19 is paying it, the child support is not taxable as income.
20 It is not deductible to the father who pays it as an
21 expense. Are we changing both those things?

22 Ms. Gulya. No. Again, we were just looking at
23 child support that is received from divorce settlements
24 or other official legal separation documents. Again, it
25 is only for purposes of determining an income level for

1 purposes of this program. Many other assistance-type
2 programs, such as low-income housing, AFDC, look to
3 levels of income, including child support, in determining
4 their eligibility requirements. We view the EITC as a
5 category of a program. And within that category, it is a
6 legitimate concern to see where the sources of income
7 are. Child support received form a divorce settlement is
8 one of those.
9 Senator Breaux. So it is going to amount to a
10 double taxation on the child support.
11 Mr. Kies. Senator Breaux, can I make just one
12 clarification about that? I think that Treasury will
13 confirm that in their measure of expanded gross income,
14 there was a lot of discussion about the fact that they
15 included, for example, the rental value of housing.
16 There are articles written saying that they tax the
17 rental value of housing. That was never correct. They
18 do not tax the rental value of housing; they just include
19 it in the measure of economic income. I think the same
20 principle applies here, that we are including certain
21 items for purposes of determining the economic capability
22 of an individual, to determine whether or not a transfer
23 payment should be made.
24 Senator Breaux. The concern is that we are only
25 doing it for poor people in this case.

1 Mr. Kies. But they are the only people who qualify
2 for this credit. That is true.
3 Senator Breaux. Yes. But you are not proposing to
4 change the child support laws for somebody who is making
5 $100,000 a year, are you?
6 Mr. Kies. No. And we are not proposing to tax
7 people who get child support payments either. It is not
8 going to be subject to income tax.
9 Senator Breaux. It is a tax increase by lowering
10 the earned income tax credit that they might get.
11 Mr. Kies. It is only going to be used for
12 determining eligibility for a transfer payment.
13 Senator Breaux. If you are not eligible, you do
14 not get the benefit. Therefore, you pay more.
15 Mr. Kies. You do not get the transfer payment.
16 Mr. Samuels. Senator Breaux, just a couple of
17 points. First, there are a number of phase-outs of
18 various provisions, based on income at the higher income
19 levels. We do not include child support for any of
20 those.
21 In this particular case, we estimate that the
22 average recipient of child support has about $3,000 of
23 child support. The average reduction in their earned
24 income tax credit is $549, so that is what they will
25 suffer in terms of their after-tax income.

1 So we think that this is a change. And, more
2 importantly, everybody should realize what we are doing.
3 More importantly, there is no way for the IRS to check on
4 who gets child support. There is no reporting to the
5 IRS. If we want to set up a reporting system, we will
6 have to have everyone who pays child support report that
7 to the Internal Revenue Service.
8 When a person pays child support to a former spouse,
9 that person does not necessarily know whether that former
10 spouse is going to be an EITC recipient, whether they
11 qualify for the EITC. So it is a very serious
12 administrative problem that we think will increase the
13 error rates that we are all concerned about.
14 Senator Breaux. I find it fundamentally wrong. Is
15 there any other place in the Tax Code--and maybe there
16 is; if there is, I am wrong--is there any other place in
17 the Internal Revenue Code of this country that we
18 consider a retired disabled person's Social Security
19 benefits as income qualifying or disqualifying them for
20 any program that you can think of?
21 Mr. Kies. I believe Treasury includes that in the
22 definition of expanded gross income for defining income
23 class, do they not?
24 Mr. Samuels. Mr. Kies, I think we are talking
25 about a completely different concept. We are not talking

1 about what the Internal Revenue Code defines as income.
2 We are talking about a classification for purposes of
3 distributing the burden and benefits of various tax
4 provisions. I do not think anyone is suggesting that one
5 incorporate either the Treasury's method of distributing
6 income measurements that are used for a very specific
7 purpose, or the Joint Committee's method for deciding
8 whether people will get certain tax benefits, or be
9 subject to additional taxes.
10 Senator Breaux. I am sorry I have taken so much
11 time.
12 The Chairman. Just let me point out that child
13 support is considered in a number of means-tested
14 programs. In the case of AFDC, all but the first $50 of
15 child support received per month is included as income
16 for recipients. Most housing assistance programs use the
17 same eligibility determination standards in which all
18 child support received is counted in determining
19 eligibility. Child support payments are counted as
20 income for recipients of food stamps, disregarded from
21 the income of payors. Child support payments are counted
22 as income for recipients of school lunch and breakfast.
23 So in the question of determining whether or not it
24 is income, there is great precedent for it.
25 Now let me make the point, first of all, that 85

1 percent of EITC really is a cash payment, income
2 redistribution. Is that correct, Ken?
3 Mr. Kies. Yes, sir.
4 Mr. Samuels. Mr. Chairman, could I just mention
5 one point which I think is very important?
6 The Chairman. Let me just continue, Mr. Secretary.
7 I think it is important to understand that what we
8 are trying to do is get a more accurate picture of what
9 the income of the individual is because, after all, we
10 are asking other low- and middle-income taxpayers to pay
11 taxes for this social program. Make no mistake about it.
12 So what we are trying to do here is develop a test that
13 is fair, and that is equitable.
14 As I say, there is precedent in considering income
15 as to whether or not one is eligible to include these
16 factors we have here. Is there any reason not to include
17 tax-exempt interest as part of the income of an
18 individual? We have talked about child support. We have
19 talked about non-taxable portions of Social Security. We
20 can always try by anecdote to get some unfortunate
21 situation but, basically, the purpose of these reforms is
22 to focus the program on those in need. That is the whole
23 intent, and it seems to me that is makes great sense to
24 consider many of these items because we are asking other
25 middle-class taxpayers to finance the cost of these cash

1 payments.

2 Mr. Kies. Mr. Chairman, I just wanted to make one
3 point because it was mentioned earlier today, and that is
4 the composition of the payments. I think it is very
5 important, when you are talking about this, not to use
6 the arcane budget scoring rules that are used for
7 purposes of this reconciliation process, but to really
8 sit and think about what this program is doing for
9 working American families.

10 We estimate that almost 80 percent of the payments
11 will offset payroll taxes and income taxes. So it is a
12 very significant offset to taxes that are borne by low-
13 income working Americans. That does not include excise
14 taxes and other taxes.

15 So, in our view, this is not a transfer payment
16 program; this is a program that cuts taxes on working
17 Americans to get them off of welfare and onto work. And,
18 when you actually look at the proposal, and see the
19 effect of it, it really is a body blow to the group of
20 taxpayers who are now getting the benefit of these tax
21 cuts that are in the proposal.

22 We estimate that 17 million working families will,
23 as a result of this proposal, have an immediate tax
24 increase of $281, which will grow to $457 in the year
25 2005. More importantly, the way the proposal is

1 structured, the phase-out rate effectively starts to
2 increase, and it is sort of a creeping tax increase as
3 you go through the years. By the year 2005, we estimate
4 that families with children, one out of five, will be
5 thrown off the program. They will not be entitled to get
6 a credit.

7 So this is not a situation where someone is reducing
8 the growth of the program. This is a situation where the
9 effect of the proposals is to produce very serious damage
10 to those working Americans to whom the program has been
11 targeted.

12 The Chairman. Just let me thank you, Mr. Samuels.

13 Just let me point out that this is the fastest
14 growing entitlement on the books. It has grown something
15 like 1,100 percent in the last 10 years. In the last 5
16 years, the credit has grown something like 14 plus
17 percent to 36 percent.

18 This program is not going to be reduced as a result
19 of these changes. As a matter of fact, it will continue
20 to grow. What we are trying to do is make certain that
21 the program is focused on those it was intended to help.
22 Make no mistake about it, 52 percent of the recipients do
23 not pay any taxes at all. So it is a social welfare
24 program, and should be recognized as such.

25 Brig, do you want to go on?

1 Ms. Gulya. Yes, sir. The other modification to
2 AGI that we have is that we exclude certain items. These
3 items are net losses from rents and royalties, net
4 capital losses, net losses from sole proprietorships,
5 partnerships, S corporations, real estate mortgage
6 conduits, trusts and estates, and also net operating
7 losses.
8 By broadening the definition of AGI used in phasing
9 out the EITC, this will prevent persons with substantial
10 income from sources other than their earnings from
11 claiming the credit.
12 The final compliance piece of our proposal would
13 double civil penalties applicable to income tax return
14 preparers filing returns claiming the EITC. This
15 provision would help address concerns raised with respect
16 to the high incidence of fraud in tax returns claiming
17 the EITC. Again, this doubling on income tax return
18 preparers, not anyone who is claiming the credit.
19 Senator Moseley-Braun. Mr. Chairman?
20 The Chairman. Yes. The Senator from Illinois.
21 Senator Moseley-Braun. Thank you.
22 Mr. Chairman, I did not react quickly enough, I am
23 afraid, because I really had wanted to try to get some
24 sense of the rationale with regard to the change in the
25 definition of disqualified income, trying to get some

1 rationale for why it was that child support was taken
2 out. Including child support as part of the AGI
3 definition for phasing this out seems to me to create a
4 double whammy on families with children, particularly
5 where there is a single parent--a woman in most
6 instances--trying to take care of a child.
7 Certainly, given all the other information that this
8 Committee has had regarding the situation of children in
9 this country, the fact that so many children are in
10 poverty, and that one of the leading causes for that is
11 inadequacy of child support, to add child support as one
12 of the items counted in determining the phase-out of the
13 EITC seems to me to just exacerbate the situation that
14 working mothers find themselves in. It will effectively
15 mean a tax increase on them, but one that is specifically
16 targeted to the fact that they are receiving some help
17 with their children's support.
18 I want to understand what possible rationale there
19 could be. The Chairman mentioned fairness, and I just
20 cannot see any fairness in including child support as
21 part of the AGI definition used for phasing out the
22 earned income tax credit.
23 I would like to ask the staff, what was their
24 thinking in including child support, and whether or not
25 this would impact in a negative way on children?

1 Ms. Gulya. Our rationale for including child
2 support was looking at other eligibility items that are
3 included in other entitlement programs, such as AFDC,
4 low-income housing assistance. Those programs all look
5 at sources of income in determining their eligibility
6 requirements, including child support.
7 It is our belief that the earned income tax credit,
8 as an entitlement program, must look to the same kinds of
9 requirements that those programs do in determining their
10 eligibility. So that is why we included it--to bring it
11 in line with the other entitlement programs and what they
12 look to in determining how people qualify to receive
13 assistance.
14 The Chairman. Maybe I read these before you came
15 in but, under AFDC, all but the first $50 in child
16 support received per month is included as income for
17 recipients. Most housing assistance programs use the
18 same eligibility determination standards, in which all
19 child support received is counted in determining
20 eligibility. Child support payments are counted as
21 income for eligibility for food stamps. Child support
22 payments are counted for school lunch and breakfast
23 programs.
24 So, for the same reasons that it was included in
25 those programs as a means of determining eligibility, it

1 was also included in this program.

2 Senator Moseley-Braun. But it would seem to me,
3 given the way the EITC is calculated, counting child
4 support as income would just make it more difficult to
5 administer.

6 The fact is that the child support payments will
7 allow for a slippery slope in terms of the administration
8 of the program, which would probably result in more
9 families with children than not being excluded from
10 participation. And there is no indication that the IRS
11 has the ability to track child support payments of
12 custodial parents in a way that would allow it to
13 administer EITC rationally, given this new role.

14 Mr. Samuels, would you comment on that?

15 The Chairman. Let me just make the comment that 85
16 percent of the payments are cash payments. This is a
17 social program, it is an entitlement, it is an income
18 redistribution.

19 So there is no reason not to consider child support
20 in this program, when it is considered in many of the
21 other programs. It is a question of trying to get the
22 program focused on those most in need. And the theory is
23 that this is an income that ought to be considered. Now
24 different people will disagree.

25 Senator Moseley-Braun. But Mr. Chairman, this is

1 very different from the other programs you mentioned.
2 There is no bureaucracy involved here. There are no
3 administrative costs associated with the EITC.
4 The Chairman. But there has been 30 to 40 percent
5 waste, fraud and abuse down through the years.
6 Senator Moseley-Braun. And you recall, sir, in the
7 hearings we had on this, on the EITC, the IRS admitted
8 that much of that number was a function of their own
9 error, not individuals trying to game the system of
10 anything, it was just a mistake because of the
11 complications of computation.
12 The Chairman. We had hearings in Government
13 Affairs which showed that a large amount of this fraud
14 was gaming, sometimes on the part of a professional tax
15 preparer who submitted forms for those who were not
16 entitled to it.
17 There were serious questions of individuals
18 overstating. One of the ironic facts of this particular
19 program is that the IRS ordinarily has to guard against
20 people understanding their income, whereas in this case
21 the problem is overstating, particularly in the case of
22 self-insured. So GAO has come up with studies showing
23 that there have been very significant problems with fraud
24 and abuse. But, again, what we are trying to do through
25 these reforms is to focus the program on those that

1 should be qualified and eligible for it.

2 The program is not being cut back.

3 Senator Moseley-Braun. And certainly, sir, no one
4 would object to focus and being fair with this, or
5 stamping out waste, fraud and abuse. My concern, and the
6 concern that I hope the Committee will take at good look
7 at, is the impact on children and on working women who
8 are supporting their children in many instances by
9 themselves, with inadequate child support.

10 We already know, and we have had hearings here,
11 about how difficult it is for working divorced mothers to
12 collect child support as it is. Now we are going to say,
13 if you are lucky enough to get it, it is going to be
14 counted against you for purposes of the earned income tax
15 credit.

16 And I would point out again that 80 percent of the
17 EITC refunds to which you refer refunds payroll and
18 income taxes paid in by the recipient. This is not
19 welfare in the classic sense of just a check coming in.
20 This is a refund on taxes that working people have paid.

21 Again, with regard to this particular part about
22 child support, counting child support, it just seems to
23 me that puts a triple whammy on working women who are
24 trying to support their children. If they are lucky
25 enough to get child support, this proposal means they

1 will be punished by the Government for working and
2 collecting some portion of child support from the other
3 parent, the non-custodial parent.
4 Mr. Samuels, I had a question pending for you, if
5 you could respond.
6 Mr. Samuels. Senator, we view this very
7 differently than the entitlement programs that have been
8 mentioned. This is a program for people who are working;
9 it is not for people who are not working. This is to
10 encourage people to work, to get off welfare and onto
11 work. And I must say that, looking at the overall thrust
12 of this proposal, it is going to have a negative effect
13 on people who are trying to get off of welfare and onto
14 work.
15 We are very concerned about the issue of errors.
16 There is a lot of discussion we have had. We testified
17 before the Chairman earlier this year on this issue.
18 A couple of points. One, a lot of the statistics
19 and comments are based on old information. We have taken
20 very aggressive steps to try to deal with the error rate.
21 I think when you discuss it, you should discuss it in
22 terms of what the situation is now, not what it was
23 before numerous steps have been taken.
24 There is a part of this package that we support, and
25 those are the provisions that deal with compliance, which

1 were in the President's budget proposal. Those are in
2 the package. Over the 7-year period, they constitute
3 about 7 percent of the total. So 93 percent is not
4 dealing with compliance, it is dealing with this child
5 support, it is dealing with taking workers who are not
6 living with qualifying children and denying them the
7 credit that is an offset to their payroll tax liability.
8 It is changing the phase-out rate, which is done in a
9 way, as I said earlier, is a creeping tax increase. When
10 you actually look to see what happens, it is a creeping
11 tax increase on people who are working, earning
12 approximately $11,600 and more.
13 So it is not just refiguring the program at the top
14 end; it hits a very large number. As I said earlier,
15 about 17 million taxpayer will be hit by these changes.
16 So these are very significant changes to the only program
17 we have that rewards work. Given all the debate on
18 welfare, it seems to us that this is not the time to cut
19 back in these various ways on people who are actually out
20 there doing their best, playing by the rules and working.
21 Senator Moseley-Braun. Mr. Samuels, how much of
22 the money goes to the question of compliance? How much
23 in the Chairman's Mark goes to the compliance mechanism,
24 and how much of the cuts will actually go to cutting the
25 actual operation of the earned income tax credit on

1 working people? I think it is important to separate out
2 how much goes for which.
3 Mr. Samuels. Our estimate is that about 7 percent
4 over the 7-year period goes to compliance, and the
5 balance goes to reducing the program and raising taxes on
6 people who are playing by the rules.
7 Senator Moseley-Braun. So 93 percent are actual
8 reductions in the earned income tax credit for working
9 people, working poor.
10 Specifically with regard to child support payments
11 being counted now, what impact is that likely to have in
12 terms of reducing or increasing the taxes paid by working
13 mothers?
14 Mr. Samuels. We estimate that the average child
15 support payment that would be subject to this provision
16 is about $3,000, and would result in an average tax
17 increase in 1996 of about $550.
18 Senator Moseley-Braun. So the average working
19 mother would pay a tax hike of $550 as a result of this
20 proposal?
21 Mr. Samuels. Right.
22 Senator Moseley-Braun. Mr. Chairman, I know what
23 you said you are trying to do in terms of focus and
24 fairness, I frankly cannot imagine but that the proposal
25 as presently written will do that. In fact, I think it

1 will have the untoward effect of being a tax hike on
2 working women who have children and are trying to support
3 those children.
4 We have had testimony in other parts of the
5 Committee, on other occasions, about the situation of
6 children in these United States. Twenty-three percent of
7 our children fall below the poverty line. That gives us
8 the highest level of children in poverty in all the
9 industrialized world.
10 This proposal, specifically as it touches on child
11 support, will just exacerbate that dismal and
12 embarrassing record. I would encourage the Chairman to
13 take a good hard look at whether or not we can ameliorate
14 the impact on working women.
15 The Chairman. Mr. Kies, would you care to comment?
16 Mr. Kies. Senator Roth, I would just point out
17 that I believe that the intention of this part of the
18 proposal, along with most of the other elements, is to
19 measure the amount of economic resources that an
20 individual has.
21 Just by way of example, when I was in private
22 practice, I represented a person in a divorce settlement
23 where they received $5,000 a month of child support.
24 That would be $60,000 a year. That individual had earned
25 income of around $15,000 a year. I do not think that

1 most people would believe that someone with $75,000 of
2 resources needed the earned income tax credit.
3 Now the question is, what is the right point at
4 which to measure economic need? I think the point you
5 have made, which is that child support payments are
6 included for purposes of other forms of transfer
7 payments, really is the key point here.
8 That is, should this be part of the measure of
9 determining whether there is economic need which
10 justifies granting the credit?
11 Senator Moseley-Braun. Mr. Kies, that is really
12 misleading. Frankly, it is up to that person, the
13 hypothetical you just gave, and I hope we are not
14 legislating based on hypotheticals here. That
15 hypothetical depends upon her getting that child support
16 to begin with. And there is not a divorced woman out
17 here that does not tell you that she holds her breath
18 month to month, to make certain that the checks actually
19 get there in time to support the kids.
20 So the fact is that child support is very different.
21 It is not a regular payment like getting a check you can
22 count on every month, for most women. Now there are the
23 exceptions, people who have a lot of money, for whom this
24 is just a regular matter. And you are correct. As to
25 those high-income taxpayers, no one is looking to extend

1 the EITC to them.

2 But the average working woman can only count on
3 child support when she has got it. And to penalize her
4 now by counting that, so that the refund on taxes she has
5 paid at her job get reduced, is the issue that I am
6 trying to raise for purposes of this discussion.

7 Mr. Kies. And I think you are quite correct. It
8 should only be counted if the individual receives it.
9 Indeed, that is the way the proposal works. It is only
10 counted for a particular year if it is paid during that
11 particular year.

12 Senator Moseley-Braun. IRS does not have a
13 mechanism for doing this, Mr. Kies. That is the
14 testimony we had.

15 The Chairman. Well, the hour is growing late. Are
16 there any more questions for Brig?

17 Senator Graham. Mr. Chairman, I have a question on
18 this point. I apologize for being detained on the floor
19 after that last vote. I have a few questions that roll
20 back into some of the previous parts of the walk-through,
21 if I could go over those.

22 The Chairman. Please proceed.

23 Senator Graham. On the EITC, on page 82 and 83,
24 the various listings of items to be included and
25 excluded, is there a dollar number associated with how

1 much each of those will produce? And is there some sense
2 of what the administrative cost of monitoring those will
3 be? I share Senator Braun's concern about the difficult
4 of keeping up with, for instance, the child support
5 payments.
6 Ms. Gulya. I can provide you with a number for
7 both the block of items in A and items in B. In A, it
8 would have an outlay reduction effect of approximately
9 $10.6 billion.
10 Senator Graham. And how is that allocated among
11 the four sub-items?
12 Ms. Gulya. That I do not have at this time.
13 Senator Graham. Could you provide that tomorrow?
14 Senator Breaux. The total of A is 10.2?
15 Ms. Gulya. Ten point 6.
16 Senator Breaux. Ten point 6 billion?
17 Ms. Gulya. Roughly. The thing to remember about
18 the numbers I am giving you is that there is an
19 interaction, so that you cannot just pull them out
20 piecemeal. The estimation has been done looking at the
21 different pieces of the proposal in conjunction with the
22 other pieces.
23 Senator Graham. Could you give us your best
24 estimate of what the individual four components
25 contributed towards that 10.6, with whatever caveats you

1 think are appropriate?

2 Mr. Kies. I think the best we could do, Senator

3 Graham, because of the phenomenon of stacking, is to

4 identify, for example, the relative magnitudes of each of

5 those, how much each of those categories of income have

6 been taken into account for purposes of determining these

7 effects.

8 So one piece of it may represent one-tenth of the

9 total, one may represent one-half. So it would at least

10 give you an idea of the relative magnitude. But it is

11 purely a function of which order you stack them in as to

12 how much revenue or outlay effect is attributable to

13 each. So it can be very arbitrary, depending on the

14 order. But I think it would give you a pretty good idea

15 of the relative magnitude if we told you the amount of

16 each of those classes of income that we have assumed in

17 connection with these estimates. We can get you that,

18 and I think that would help answer the question.

19 Senator Graham. All right. When I get the

20 numbers, there may be some more questions as to the

21 methodology.

22 Mr. Kies. Sure.

23 Senator Graham. All right.

24 Then as to B, the excluded items?

25 Ms. Gulya. That would be $1.4 billion over 7

1 years.

2 Senator Moseley-Braun. Is that for all four?

3 Ms. Gulya. Yes, Senator.

4 Senator Moseley-Braun. One point four billion over

5 7 years? And that is for all four categories--rents and

6 royalty losses, capital losses, proprietorships, and so

7 forth?

8 Ms. Gulya. Yes.

9 Senator Graham. I wonder if Mr. Samuels has any

10 comments about the first of the interaction that leads to

11 the $10.6 billion figure associated with paragraph A at

12 the bottom of page 82, the $1.4 billion associated with B

13 at the top of page 83, and then an estimate of what the

14 administrative cost might be in terms of overseeing those

15 particular items in the Tax Code?

16 I wonder if you have any comments as to whether

17 these changes are moving us towards or further away from

18 a flat tax and simplification? I would like you to

19 comment on that.

20 Mr. Samuels. I think that the biggest item is

21 adding untaxed Social Security benefits and untaxed

22 retirement benefits. One point I would like to mention

23 on the untaxed retirement benefits, these are amounts

24 that have previously been taxed that are now being

25 counted as income for purposes of this calculation. That

1 is the biggest one. Our 7-year number on that is about
2 $5.6 billion.
3 With respect to the administrative costs, as I
4 mentioned with respect to child support, there is no
5 system in place to report child support so the IRS can
6 check whether someone has received the child support.
7 We are trying to reduce errors, and make this
8 program as simple as possible. That is the point. We
9 have got low-income working Americans, and they should
10 have a simple system. Adding these new items is
11 obviously going to make the form much more complicated.
12 It is going to be more complicated for the IRS to check.
13 So it is moving in the opposite direction from
14 simplification, which I think we are all much more aware
15 of these days. In our view, it ought to be given greater
16 weight in analyzing any of these proposals.
17 As I said before, I think that the overall thrust of
18 this Mark is going to discourage people from work. It is
19 going to affect 17 million EITC recipients. And the way
20 it has been structured, over time we are going to be
21 taking families who are now receiving the income tax
22 credit, and they are just going to be dropped out of this
23 credit.
24 We have estimated, because of the way this thing is
25 structured, by the year 2005, 21 percent of families with

1 children will no longer be eligible for the credit. That
2 is one in five of the people who would otherwise be
3 getting the credit. These are families with children.
4 One in five would no longer be eligible. And that is a
5 dramatic change in the program. And it obviously results
6 in a significant tax increase on those families who
7 otherwise would have been entitled to the credit.
8 So, when you look at the whole package, it is a
9 major change. It is a reduction in the program of over
10 20 percent.
11 The Chairman. If I could just interrupt, we have a
12 copy of your press release. I think everybody has had
13 the opportunity to discuss their point of view on this
14 admittedly most important matter.
15 But the hour is late. We have been in since early
16 this morning, and I know that staff has had no time to
17 even eat, so I am anxious to bring it to an end tonight,
18 so that we can begin tomorrow with the mark-up.
19 Senator Graham. Well, can I turn to my other
20 questions then? I guess that is as far as we are going
21 to get on the EITC.
22 I am starting on page 38, which is the hospice
23 service payments. As I understand this, the proposal is
24 to cut the MBI, the hospital market basket index for
25 hospice, 2 percentage points each year between 1996 and

1 2002. That seems to be a more stringent reduction than
2 is being recommended for some of the other areas. I
3 wonder why you are proposing that.
4 Ms. Nestor. Senator, let me just say that in the
5 modifications, that is actually market basket minus 2.5
6 percentage points.
7 Senator Graham. So you have increased it?
8 Ms. Nestor. Yes, sir. And let me just say that
9 hospice service payments ----
10 Senator Breaux. Let us get that straight. On page
11 38, under number 2 for FY 1997 should be 2.5?
12 Ms. Nestor. Yes. It is market basket minus 2.5
13 percentage points.
14 Senator Breaux. For FY 1997? For every year?
15 Ms. Nestor. For each year between 1997 and 2002.
16 Senator, let me say that the hospice program is the
17 fastest growing program in the Medicare program. In
18 recent years, it has grown as much as 40 percent a year.
19 This market basket inflation increase that we are setting
20 for hospice is the same increase that we are giving to
21 the hospitals and to the other areas, the nursing homes
22 and home care. So we are setting the same inflation
23 update. However, I just want to point out that this
24 program has been growing much more rapidly than the rest
25 of the Medicare program.

1 Senator Graham. Well, have you evaluated what the
2 relative cost factors are of having a person expire,
3 since the only persons who are eligible for this program
4 are those who are within 6 months of death, expire under
5 a hospice service setting, as opposed to in alternative
6 settings, particularly either in nursing homes or
7 hospitals?
8 Ms. Nestor. Senator, we think this is a very
9 valuable program, and this is no reflection on that. We
10 are just handling all the inflation updates the same.
11 This program is actually paid on a little different
12 basis, by patient, today. And that would continue.
13 Senator Graham. I got the impression that you
14 thought the growth in the program was a negative. I
15 could argue that the growth in the program is a positive
16 because it is shifting terminal patients into a more
17 appropriate and less expensive setting.
18 Ms. Nestor. Certainly, Senator, on many of the
19 non-hospital services I think there is an amount of
20 volume growth that is due to more appropriate settings.
21 Senator Graham. On page 49, under the issue of
22 fraud, there is a reference made to safe harbors. It
23 says, "The Secretary shall publish an annual notice in
24 the Federal Register soliciting proposals for
25 modifications of existing safe harbors." Could you

1 explain what you contemplate there?

2 Ms. Nestor. Senator, there has been an interest in

3 clarifying some of the current laws for Medicare fraud

4 and abuse. We do have some of that clarification in the

5 law now through safe harbors which say what kinds of

6 things providers can do that are allowed under the law.

7 This is just expanding some of those, so that we

8 would have some more safe harbors, so it would be very

9 clear to providers what things are considered fraudulent

10 and not.

11 Senator Graham. Have you discussed this matter

12 with some of the U.S. attorneys who are involved in

13 dealing with Medicare fraud?

14 Ms. Nestor. Yes, sir. We actually have worked

15 over the last 2 years with Senator Cohen's staff, who

16 have worked very hard with a number of these groups on

17 these issues.

18 Senator Graham. And are those U.S. attorneys

19 supportive of expanding this concept of interpretive

20 rulings and safe harbors?

21 Ms. Nestor. Senator, that is my understanding.

22 Let me check to make sure.

23 Senator Graham. Could you provide us with some

24 data from U.S. attorneys?

25 Ms. Nestor. All right.

1 Senator Graham. Since we are not going to be able
2 to call any of them as witnesses, I would like to get
3 their information on that.
4 Ms. Nestor. I would be glad to do that.
5 The Chairman. Senator Graham, I understand that we
6 are fairly close to a vote. I am hopeful that we can
7 complete the walk-through tonight. We have three
8 additional items. I do not want to cut you off. On the
9 other hand, I do think it is important that we proceed.
10 Perhaps we can answer your questions informally.
11 Senator Graham. I only have a few more to go, if I
12 could.
13 On page 54, there is the description of the Belt
14 provision. At the top of the page it says that there
15 will be an order issued on October 15. The order will
16 specify the reduction in payment amounts for provider
17 services that are necessary to meet the annual spending
18 target.
19 If that Belt process is required, and I had thought
20 when I saw it, Gramm-Rudman-Hollings seems to be the
21 parent of this idea. How will that order to specify the
22 reduction of payment amounts for provider services apply
23 to all of the entities under the Medicare program, such
24 as the medical savings accounts and the home health
25 maintenance organizations?

1 Ms. James. Senator, if the Belt is triggered, if
2 the sequester mechanism is triggered, the spending will
3 take part in the traditional side of the Medicare program
4 since we have fixed, and we know how much we are going to
5 be spending on the other side. So it would apply only to
6 the fee-for-service side of the Medicare program.
7 Senator Graham. So you are saying that, if you do
8 not reach the target you have set under the Medicare
9 choice in a particular year--for instance, in 1999, when
10 you have a target of $6 billion--if you do not reach that
11 $6 billion, whatever that shortage is will come out of
12 the fee-for-service side of the equation?
13 Ms. James. Yes, Senator. We have the growth rate
14 on the other side fixed at a 4.3 percent growth per
15 capita. And we cannot spend any more on that side
16 because that is a fixed payment amount.
17 On the traditional side, we still have an open-ended
18 entitlement program. So this is trying to establish some
19 discipline on that side. And the per-capita growth rate
20 on the traditional side is higher than on the Medicare
21 choice side.
22 Senator Graham. So when you tell the beneficiaries
23 of Medicare that you are not going to touch fee-for-
24 service, that they are going to have fee-for-service as
25 they know it, is that not a breach of that commitment?

1 You are going to be telling them, if you do not meet
2 your goals, even if it is in goals that were set for
3 medical savings accounts, and, using my hypothetical, by
4 definition you have not met the goals because you have
5 not got to the $6 billion, that it is not going to be the
6 medical savings accounts--not the health maintenance
7 organizations--it is going to be fee-for-service that
8 will be the party out of which those failed savings are
9 accomplished. Is that fair?
10 Ms. James. Senator, I do not want to repeat
11 myself. But again, we know that we have controlled
12 spending on the one side, and this was the best way to
13 deal try to deal with the spending on the other side.
14 Senator Graham. For instance, Senator Breaux and I
15 were just ~~looking at a study done by one of the most~~
16 respected health economists in the nation, saying that
17 his firm predicts that the medical savings account will
18 cost $15 billion, not the cost figure that you are going
19 to produce tomorrow when we see the numbers of how the
20 $46 billion was arrived at.
21 Suppose Mr. Lewin is right, that it does have a $15
22 billion cost upside? I assume your increased cost is
23 less than $15 billion. And it blows these savings so
24 that the result of that failed experiment is going to be
25 higher fee-for-service charges?

1 Ms. James. Well, we certainly do not expect that
2 the choice plans are all going to be medical savings
3 account plans. I want to make that clear. The
4 understanding is that would be only a small part of it.
5 And we do know that, for people opting into the choice
6 side, the Government spending for those persons will be
7 predictable because we will know what we are going to
8 spend.
9 Therefore, we simply do not have any incentives. We
10 have struggled and struggled on the other side to have
11 some incentives to try to control the open-ended
12 entitlement nature of the other side of the program. So
13 this is very similar to many of the provisions that were
14 in last year's bills, to try to control this.
15 Senator Graham. We have had evidence already that
16 you are proposing to restrain the growth in Medicare, a
17 program that deals with some of the frailest people in
18 our society, at a rate which is below the rate projected
19 for the private sector, in terms of private insurance
20 plans. It is below the rate that we have for our Federal
21 health insurance plan, which happens to be an 8 percent
22 growth during most of the years from now until the end of
23 the century.
24 Yet you are going to be shocked, shocked, shocked
25 when fee-for-service on Medicare does not reach that

1 goal. And the consequence of that failure to meet that
2 goal will fall on the fee-for-service program.
3 The Chairman. If I could interrupt, I think the
4 time has come when we must move on.
5 Senator Graham. Well, I will go on to the next
6 question. I have three more questions.
7 The Chairman. I would ask that you make the
8 discussion as brief as possible.
9 Senator Graham. All right. I will make it as
10 brief as possible. And I will conclude several of these
11 with a request for additional follow-up information.
12 Senator Moseley-Braun. Senator Graham, just one
13 second. Mr. Chairman, I understand that we are all
14 tired, and this can go on, but these are some very
15 important issues. This is a very important Mark,
16 affecting millions and millions of Americans. We are not
17 having public hearings. We have a group of Republican
18 staffers sitting here giving us the party line on this
19 stuff. It seems to me that, at a minimum, we ought to be
20 able to ask questions about it.
21 Senator Graham has some questions on the effects of
22 the Medicare proposals. It just seems to me that, at a
23 minimum, you would let us at least put the questions in
24 the one little tiny opportunity that we have. We are not
25 really having a chance to explore this, given the gravity

1 and the importance of this situation.

2 I would think that with something a significant as

3 this Mark, we would have public hearings. We are

4 apparently not going to have public hearings. And we are

5 not going to have a chance to go through this step-by-

6 step and detail-by-detail. That is bad enough. But to

7 rush to judgment on this stuff, without even giving the

8 Members a chance to ask their three or four questions on

9 these important issues, just seems to me to be tragic.

10 It is bad enough that we are going to do some of this.

11 As I said to you the other day when I ran into you

12 on the elevator, there are some parts of this proposal

13 that are thoughtful. And I do not think you will get a

14 whole lot of questions on those parts of the proposal.

15 What you will get is consensus, and that will be the easy

16 part. But there are some tricky questions here, and some

17 very serious, dramatic, major changes in the way that our

18 country operates, and the people in this country get a

19 chance to access health care.

20 And I just do not think it is right, just because it

21 takes an hour more, or two hours more, or even three

22 hours more, that we be limited as Senators to being able

23 to ask questions about the Chairman's Mark.

24 The Chairman. Well, the Chair would point out that

25 we have been here since 9:00 a.m. The purpose of the

1 meeting today, of course, is to go through the proposal,
2 a walk-through. There will be considerable opportunity
3 in the future to debate the amendments, in the Committee
4 and, of course, on the floor. We know that there are
5 votes coming up in the near future, so we are just trying
6 to complete the walk-through now so that we can continue
7 tomorrow.

8 Senator Moseley-Braun. So we will all get a chance
9 to ask questions?

10 The Chairman. I would like to ask Kathy Tobin if
11 she would walk us through the last three provisions.

12 Senator Graham. All right. Mr. Chairman, when we
13 finish this, can we come back and complete the walk-
14 through on Medicare and Medicaid?

15 The Chairman. Well, we did the walk-through. I
16 know some of you were necessarily away. But we have
17 tried to provide everybody an opportunity.

18 Senator Graham. Well, if the answer to that
19 question is yes, that we will come back to Medicare and
20 Medicaid after we finish these additional items, I will
21 of course defer.

22 Senator Breaux. I think the answer is no.

23 Senator Graham. If the answer is no, then I want
24 to place my questions.

25 The Chairman. Sure. I want to give everybody the

1 opportunity. My concern is that we are coming up to some
2 votes. So let us proceed with the final three items, and
3 then come back to whatever questions until we have a
4 vote.
5 Ms. Tobin. Thank you, Mr. Chairman.
6 Included in the Chairman's Mark is the welfare bill
7 which passed the Senate on September 19, 87 to 12. The
8 only difference between the Senate-passed welfare bill
9 and what is included in the Chairman's Mark is that the
10 Chairman's Mark does not include the refundable tax
11 credit for adoption expenses.
12 Because the welfare bill has already been debated
13 and marked up in this Committee, I will focus my remarks
14 on the three following provisions. These provisions were
15 included in the Chairman's modifications that were passed
16 out earlier today, starting on page 11.
17 The first provision is the social services block
18 grant. Today, the social services block grant is capped
19 at $2.8 billion a year. Block grant funds are allocated
20 to States, based on the State's share of total
21 population. No matching funds are required for States to
22 receive block grant funds.
23 States currently have broad authority on how their
24 funds are to be used, and who may be served. Block grant
25 funds are usually used to supplement existing programs,

1 rather than to enact new programs. The Chairman's Mark
2 reduces the social services block grant by 20 percent a
3 year, beginning in fiscal year 1997.
4 The second provision deals with foster care. Title
5 IV-A of the Social Security Act helps States pay for
6 foster care and adoption assistance for children who are
7 AFDC eligible. From 1994 to 1999, the AFDC foster care
8 caseload is expected to grow from 245,000 to 298,000
9 children. That is a 22 percent increase. At the same
10 time, however, the cost for administering the AFDC foster
11 care program is expected to increase from $1.2 billion to
12 $2.1 billion. That is an 83 percent increase.
13 Because of the escalating administrative costs in
14 the foster care program, the Chairman's Mark caps each
15 State's administrative costs at a growth rate of 10
16 percent per year. This follows the recommendations set
17 forth in the 1995 red book published by the Department of
18 Health and Human Services Inspector General's office.
19 The last provision involves costs of providing child
20 support services to non-AFDC families. Although States
21 are currently required to charge an application fee for
22 non-AFDC families to use child support services, many
23 States only charge a nominal fee. Since 1984, the cost
24 of providing services to non-AFDC families has risen over
25 600 percent, to $1.1 billion in fiscal year 1994 alone.

1 Collections to offset these costs, however, have only
2 increased 3 percent, or we are collecting approximately
3 $33 million in 1994.
4 The Chairman's Mark requires that States collect an
5 amount equal to a $25 application fee, and 10 percent of
6 collections for non-AFDC families.
7 This follows similar recommendations made by the
8 General Accounting Office and the Inspector General's
9 office at the Department of Health and Human Services.
10 That concludes the three items.
11 The Chairman. Any questions? Senator Graham?
12 Senator Moynihan?
13 Senator Moynihan. Mr. Chairman, I think we really
14 have to ask, what are the grounds for cutting Title XX by
15 20 percent? That is one of the few flexible provisions
16 we have had in law for 20 years now.
17 Ms. Tobin. Yes, sir.
18 Senator Moynihan. It is everything we have said we
19 want States to be able to do. And now we are going to
20 give them less to do it with.
21 Ms. Tobin. Currently, the majority of Title XX
22 money, as you said, is very flexible. It is used to
23 supplement existing programs. As we are in a budget
24 crisis at the moment, it is easier to reduce this. We
25 looked at many options. Instead of reducing a single

1 program like foster care or adoption by X percent, the
2 social services block grant covers a variety of programs.
3 Some of those programs already have existing funding
4 extremes. We are just cutting back the supplement.
5 Senator Moynihan. And you saved over the 7-year
6 period?
7 Ms. Tobin. Yes, sir. Over the 7-year period, we
8 saved $3.4 billion.
9 Senator Moynihan. Well, obviously, we do not agree
10 with that, but that is a clear answer. Thank you.
11 The Chairman. Senator Graham?
12 Senator Graham. Mr. Chairman, I am going to
13 proceed with my questions, but I might say that the last
14 answer was an ominous one. Essentially, what you said
15 was that, if you had to make a judgment as to where to
16 cut funding, the easiest place to do it is with block
17 grants. That is what many of us are concerned about.
18 Senator Moynihan. That is what will happen to
19 block grants.
20 Senator Graham. As we are moving so many of these
21 programs, whether it is Medicaid or welfare, into a block
22 grant form, that they will in a few years have someone
23 sitting at exactly the same desk asking why did you cut
24 the welfare block grant, or why did you cut the Medicare
25 block grant. And they will be able to refer to your

1 answer as the basis.

2 Ms. Tobin. All programs under our jurisdiction for

3 AFDC, foster care and social services are facing a cut.

4 So this is following that line.

5 Senator Graham. On page 55, is the extension of

6 hospital insurance to all State and local government

7 employees? In the chart that was up on the easel earlier

8 in the day, which shows the lines relative to the

9 solvency of the trust fund, it indicated that one of the

10 principal reason why the lines where looking better was

11 because of the additional revenue coming into the Part A

12 trust fund through those increases.

13 What dollar figure are we associating with that?

14 Ms. James. It is $13.5 billion.

15 Senator Moynihan. We touched on this earlier.

16 Senator Graham. As I understand it, half of that

17 will be paid by the employee and half by the employer,

18 which will be the State or local government. Is that

19 correct?

20 Ms. James. Yes.

21 Senator Graham. So is this, in effect

22 approximately a $7 billion unfunded mandate that we are

23 about to give to the States?

24 Ms. James. This is an extension of the current

25 tax, equitably across everyone.

1 Senator Graham. So is the answer to the question
2 yes?
3 Ms. James. Yes.
4 Senator Graham. So that we will not belabor this,
5 I am concerned about the degree of unfunded mandates in
6 this bill. Could you prepare a summary of all of the
7 additional costs which we will be asking State and local
8 governments to undertake as a result of this legislation,
9 such as this additional tax?
10 Next, on page 57, we list here the persons for whom
11 there are currently required payments, and will be
12 required payments in the future. Have we calculated what
13 the cost of meeting the minimum spending obligations
14 outlined on page 61 will be?
15 Ms. James. Senator, these amounts will vary from
16 State to State. It is based on the amount of spending
17 that goes for mandatory services and mandatory
18 eligibility classes of people in each State.
19 Senator Graham. Do you have that number by State?
20 Ms. James. We are working with CRS and some other
21 sources to try to get that information. There is a
22 problem with trying to identify which services go with
23 certain people, so we are working on getting that
24 information.
25 Senator Graham. When do you think we will have

1 those numbers?

2 Ms. James. I am not sure, Senator. Our Medicaid

3 staff person who is working on it is going to be back

4 here in just a second, and will answer that for you.

5 Senator Graham. All right. And that leads to the

6 next question. On page 70, there is the issue of Federal

7 funding. When will we have the breakdown of the

8 allocation by State of the Federal funds?

9 Ms. James. I believe he has been working on them.

10 We will ask.

11 Mr. Ramthun. I am sorry, Senator. That is the

12 reason I was not present. I was trying to find out when

13 we are going to get those numbers. We are still doing a

14 little bit of fine tuning, and I hope to have it in the

15 next hour, but they have been saying that all day.

16 We know that every State and every Senator is very

17 interested in the outcome of the formula. I think we

18 would like to have a staff briefing to walk staff through

19 it, once we understand what the final formula elements

20 would be. Then we would be able to answer any specific

21 questions.

22 Senator Graham. When do you think you will be able

23 to have that walk-through?

24 Senator Moynihan. In the morning.

25 Mr. Ramthun. Probably first thing in the morning

1 would be the most realistic suggestion.

2 Senator Graham. Will you be able to do a
3 comparison of the numbers generated by the minimum
4 spending obligations on page 61, and the Federal
5 allocations that will be generated on page 70?

6 Mr. Ramthun. I am sorry. Where were the second
7 set?

8 Senator Graham. Sixty-one has the States will meet
9 minimum spending obligations for each of three specific
10 groups of beneficiaries. It lists those. I understand
11 that CRS is developing the number s on a State-by-State
12 basis of what that will be.

13 Then the Federal funding is on page 70. I am
14 interested in being able to see a side-by-side
15 comparison. To be parochial, what is Florida's
16 obligation going to be on page 61, as opposed to what its
17 resources will be on page 70?

18 Mr. Ramthun. Well, I am frankly surprised that CRS
19 is working on that. When I called, you told them that.
20 When I asked the Congressional Research Service, they
21 told me they could not do it.

22 Senator Graham. Well, how are we supposed to
23 intelligently evaluate whether the formula on page 70 is
24 acceptable if we do not know what the mandatory
25 obligations of our States are going to be on page 61?

1 Mr. Ramthun. I believe your State could give you
2 that information.
3 Senator Graham. You mean we have to call 50 States
4 and the District of Columbia to get the numbers?
5 Mr. Ramthun. If the Congressional Research
6 Services cannot get it for me, I do not know anybody else
7 in town who can get it for me.
8 Senator Graham. Would you agree that you cannot
9 reasonably assess this plan unless you have those two
10 pieces of information--what your costs are going to be,
11 and what your resources to meet those costs will be?
12 Mr. Ramthun. No. I do not think that is an
13 accurate assessment because the minimum set asides are on
14 a percentage basis. It could be 10, it could be 15, it
15 could be 40 percent. This does not in any way tell the
16 State how much money it has to spend. It does not tell
17 the State how much it has to spend, relative to the
18 Federal funding caps. Those are all State choices, once
19 those percentages are set in stone. It could be 100
20 percent, and we still do not tell States a dollar amount
21 below which they cannot spend.
22 Senator Graham. Well, of course, we are at a
23 disadvantage because all we have is what is written on
24 this piece of paper. We do not have legislative
25 language. It says, "States will meet minimum spending

1 obligations for each of three specific groups of
2 beneficiaries." And it lists one, two and three.
3 Mr. Ramthun. Well, they will be specific to each
4 State. So whatever Florida's past spending patterns for
5 FY 1992, 1993 and 1994 were, we take the average of those
6 three on a percentage basis.
7 I will continue to try to get those figures for you.
8 But I was told by the Congressional Research Service that
9 they could not do that calculation.
10 Senator Graham. My last question. Page 67 relates
11 to the 1115 waivers. It states that States with such
12 waivers would be allowed to continue such waivers under
13 the terms and conditions of the waiver agreement, at the
14 option of the State.
15 For instance, this means that the Tennessee plan can
16 continue under the terms of the waiver that Tennessee
17 has?
18 Mr. Ramthun. As long as it does not exceed the
19 Federal funding cap for the State, that is correct.
20 Senator Graham. Well, it is going to exceed the
21 Federal funding cap. That is why they got the waiver.
22 Mr. Ramthun. The State has not yet reached its
23 funding cap under the waiver. In my conversations with
24 the State, they do not project that they will come close
25 to reaching any of the growth rates that the House is

1 willing to give them under this proposal.

2 Senator Graham. Well, I would like to get some
3 more information about the six or seven States that have
4 waivers, and how they will be affected by this.

5 Mr. Ramthun. Well, with the exception of
6 Tennessee, every State that currently has a waiver is
7 only operating their waiver for their acute care portion
8 of their program. Now the cap for the acute care waiver
9 is a budget neutrality agreement, which puts an outer
10 parameter on how much the State can spend and still be
11 within the spending guidelines set under the terms and
12 conditions of the waiver.

13 It is not a guarantee of Federal funds over and
14 above what they might be able to get in this situation.
15 If the State were to spend as much as it could possibly
16 get, and still meet the budget neutrality test under that
17 waiver, it would put it in excess of what might be
18 considered an applicable cap. These waivers only apply
19 to the acute care side of their program. The long-term
20 care side of the program is not under a waiver. So,
21 effectively, the difference would have to be made up on
22 the other side of the program, to fit underneath this
23 cap.

24 The Chairman. Senator Moseley-Braun?

25 Senator Moseley-Braun. Thank you, Mr. Chairman.

1 You know, I used to joke about being the only single
2 working mother in the United States Senate. It is not a
3 joke actually; it is the truth. So I am very concerned
4 about these child support issues. I have raised them
5 with regard to the EITC.
6 I have another one on page 13 of the modifications
7 to the Chairman's Mark. The proposal suggests that a
8 back door tax, or a fee, would be associated with child
9 support collections, child support enforcement.
10 So, traditionally, or at least under current law,
11 the States can collect child support for AFDC, with
12 regard to non-AFDC mothers--and it generally is mothers--
13 who are trying to collect child support, the States can
14 offer them some help in collection also. But now we are
15 going to be charging $25 for an application fee and
16 another 10 percent of collections for non-AFDC families
17 who use child support services.
18 Again, Mr. Chairman, this would impact on the
19 working poor primarily, more than anybody else. I just
20 wanted to ask the staff, do you have numbers? Do you
21 have any information regarding how much this 10 percent
22 surcharge for this collection of child support payments
23 and the $25 application will generate, and what is the
24 rationale for that set of fees when, obviously,
25 collecting child support and helping working mothers

1 collect child support is something that would decrease
2 welfare expenditures, would increase contributions under
3 the EITC, based on the other side of the proposal?
4 I mean, why would you want to impair States helping
5 working mothers collect child support?
6 Ms. Tobin. That provision brings in $3.8 billion
7 over 7 years.
8 Senator Moseley-Braun. Billion or million?
9 Ms. Tobin. Billion.
10 Senator Moseley-Braun. B?
11 Ms. Tobin. B.
12 Senator Moseley-Braun. All right. Over 7 years.
13 Ms. Tobin. The thinking behind this is, first of
14 all, this was a recommendation by the IG's office at the
15 Department of Health and Human Services, and also by the
16 General Accounting Office. It is to move closer to the
17 private sector collection system.
18 Under current law, private collection agencies can
19 charge between 25 and 33 percent of collections. So we
20 are just trying to recoup some of the money we are
21 spending.
22 Actually, in order for the Federal Government to
23 break even on providing services to non-AFDC families, it
24 would require a 15 percent collection fee, and also an
25 application fee of approximately $25 as well.

1 Senator Moseley-Braun. But this $3.8 billion over
2 7 years comes directly out of the hides of those children
3 that would otherwise receive it.
4 Ms. Tobin. No, ma'am. Under the proposal it says,
5 "States would be required to collect an amount equal
6 to . . ." That does not necessarily have to come out of
7 the child support payment. The States will have the
8 flexibility to determine how to collect such fees.
9 Currently, some States are assessing fees. For
10 example, paternity has to be established. States can now
11 collect fees, the cost that the State incurred, to do
12 those paternity establishment tests. They can take those
13 fees and collect them from the non-custodial parent.
14 Other States are using fee collection processes
15 where, if the non-custodial parent refuses to pay, the
16 parent is then taken to court. Each time they have to go
17 to court, a higher fee is assessed.
18 Senator Moseley-Braun. All right. Would you then
19 be amenable that we make a legislative caveat that it not
20 come out of the custodial parent's child support payment
21 that actually goes to the children? If you are going to
22 charge a fee, it should not come from the children.
23 Ms. Tobin. The proposal is designed to give the
24 States the flexibility.
25 Senator Moseley-Braun. Well, Mr. Chairman, would

1 you consider entertaining that as a proposal, that the
2 States would have the flexibility, so long as the 10
3 percent fee did not come from the children? The 10
4 percent fee becomes a surcharge on child support.
5 The Chairman. Do an amendment?
6 Senator Moseley-Braun. We will talk to you later
7 about it.
8 Thank you. Thank you, Mr. Chairman.
9 The Chairman. Senator Breaux?
10 Senator Breaux. Mr. Chairman, I do not have a
11 question. I just want to commend your staff, the
12 Majority staff, for the work they have done, as well as
13 our staff. We have tried to keep up with the work they
14 have done. We do not always agree on the policy
15 suggestions, and there has been a lot of disagreement.
16 I want all the staff to know that we are not personally
17 disagreeing with them, but some of the policies that are
18 being offered.
19 I think that many of the areas we have seen for
20 reduction in Medicare and Medicaid are very similar to
21 ideas that some of us have on this side. The big
22 difference is in the amounts. You amounts are much
23 larger because the targets are much larger.
24 But I just wanted to take this opportunity to say to
25 the staff--both on the Majority and Minority side--that

1 we appreciate very much all the work they have done in
2 making this presentation in a very short period of time,
3 relatively speaking.
4 The Chairman. Well, thank you. I join you in
5 congratulating the staff on both sides for a very
6 professional job.
7 I would like to announce that each Member's staff
8 may pick up a copy of the amendments in Lindy's office,
9 Dirksen 209, at 8:30 p.m. tonight.
10 Rather than meet tomorrow at 9:00 o'clock, we are
11 going to postpone it until 10:00 o'clock.
12 Senator Moynihan. Our regular hour. [Laughter.]
13 The Chairman. I think there is a little propaganda
14 there.
15 Senator Moynihan. Could I ask, Mr. Chairman, about
16 the order in which amendments will be offered? Do you
17 have any view on that yet?
18 The Chairman. We have not really had a chance to
19 determine that, but we will be happy to let you know as
20 soon as we do.
21 Thank you very much. The Committee is in recess.
22 [Whereupon, the Committee recessed at 8:00 p.m, to
23 reconvene at 10:00 a.m. on Wednesday, September 27.]
24
25

CHART 1 – SUMMARY

Senate Finance Committee
September 26, 1995

		7-Year Savings 1996-2002
Chairman's Mark:		
1.	Medicare Proposals	$270.3 Billion
2.	Medicaid Reforms	$182.0 Billion
3.	EITC Reforms--Outlay Savings	$ 32.5 Billion
4.	Welfare Reform--Outlay Savings from Finance Committee Programs in Senate passed H.R.4	$ 35.6 Billion
5.	Additional Savings in Modification	$ 8.6 Billion
6.	Total--Chairman's Mark	$529.0 Billion
Previously Enacted Legislation:		
7.	Self-Employed Health Deduction	$ 2.7 Billion
Grand Total:		$531.7 Billion
Finance Committee Instruction in the FY 1996 Budget Resolution:		*$530.4 Billion*

CHART 2 – MEDICARE

Medicare Proposal (based on specs through 9/24): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars

	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Medicare Part A:								
Provider Reimbursement Options								
PPS MB-2.5% thru 2002	-0.2	-1.3	-3.0	-4.8	-6.8	-8.9	-11.2	-36.1
Rebase Capital rates	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-2.7
Reduce PPS capital by 15%	-1.0	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-9.0
Reduce Disproportionate Share to 25%	-0.1	-0.3	-0.5	-0.7	-0.9	-0.9	-1.0	-4.5
Reduce IME to 6.7, 5.6, 4.5%	-0.4	-0.9	-1.5	-1.7	-1.7	-1.8	-1.9	-9.9
Change PPS-exempt pmt ceilings and floors	-0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.7	-2.7
NonPPS MB-2.5% thru 2002	-0.0	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-2.0
Reduce NonPPS capital by 15%	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.5
SNFs	-0.2	-0.6	-1.0	-1.4	-1.9	-2.3	-2.9	-10.4
Home Health Prospective Payment /1	0.0	-1.4	-2.3	-2.8	-3.3	-3.7	-4.3	-17.8
Hospice	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
Critical Access Hospitals, Extend MDH	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.5
AAPCC Interaction with DSH,IME,GME /2	0.0	0.9	1.6	1.8	2.0	2.2	2.5	10.7
Part A	-2.4	-5.5	-8.1	-12.2	-15.5	-18.8	-22.2	-85.8
Medicare Part B:								
Provider Reimbursement Options								
Eliminate Formula Driven Overpayment	-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-15.9
Extend 5.8% Outpatient payment reduction	0.0	0.0	0.0	-0.3	-0.3	-0.4	-0.4	-1.4
Increase Outpatient capital reduction to 15%	-0.0	-0.0	-0.1	-0.2	-0.2	-0.2	-0.3	-1.0
Freeze Ambulatory Surgical Center updates	-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.3
Revise MVPS (CF-3.65% in 96; GDP+2 thru 2002)	-0.4	-1.3	-2.3	-3.2	-4.1	-5.1	-6.2	-22.6
Freeze Clinical lab update, 65% of median	-0.1	-0.4	-0.7	-0.9	-1.1	-1.3	-1.6	-6.0
Freeze Dur Med Eqpt update, -40% on oxygen	-0.3	-0.6	-0.7	-0.9	-1.0	-1.3	-1.5	-6.2
Eliminate Ambulance Update	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8
Increase bonus to rural prim care docs	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.4
Direct payments to nurse prac/phys assts.	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.3
REACH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Interactions	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-1.4
Beneficiary Options /3								
Deductible to $150 in 96; +$10/year thereafter	-0.7	-1.1	-1.3	-1.5	-1.7	-2.0	-2.2	-10.5
31.5% Premium through 2002; rounded up	-3.4	-4.4	-4.4	-5.8	-8.5	-11.1	-14.1	-51.6
Income-related premiums	0.0	-0.5	-0.9	-1.4	-1.8	-2.1	-2.5	-9.1
Part B	-5.8	-9.4	-12.0	-16.5	-21.9	-27.6	-33.9	-126.9

DRAFT

SEP-24-95 18:07 FROM: ID: PAGE 2/4

Medicare Proposal (based on specs through 9/24): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Medicare Parts A and B:									
Medicare Second Payer		0.0	0.0	0.0	-1.3	-1.4	-1.6	-1.8	-6.0
Anti Fraud and Abuse /4		-0.2	-0.3	-0.5	-0.6	-0.7	-0.8	-0.9	-4.1
Parts A and B		-0.2	-0.3	-0.5	-1.9	-2.1	-2.4	-2.7	-10.0
Medicare Choice		-0.4	-1.0	-3.8	-6.0	-8.4	-11.6	-16.7	-47.6
Combined Total		-8.8	-16.8	-25.4	-36.6	-47.9	-60.4	-74.6	-270.3

DRAFT

COMPARISON OF SPENDING UNDER PROPOSAL WITH CURRENT LAW SPENDING

	1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Gross Mandatory Outlays for Medicare Benefits									
Current Law, BR baseline	177.8	198.6	219.1	240.1	263.0	287.7	314.8	344.8	
Proposed Law	177.8	193.2	207.1	219.9	233.7	250.1	267.7	286.8	
Difference	0.0	-5.4	-12.0	-20.2	-29.3	-37.6	-47.1	-58.0	-209.5
Less: Flat Part B Premiums									
Current Law, BR baseline	-20.1	-20.3	-22.0	-24.5	-26.1	-27.3	-28.7	-30.1	
Proposed Law	-20.1	-23.7	-26.3	-28.9	-31.9	-35.9	-39.8	-44.1	
Difference	0.0	-3.4	-4.4	-4.4	-5.8	-8.5	-11.1	-14.1	-51.6
Less: Income-Related Part B Premiums									
Current Law	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Proposed Law	0.0	0.0	-0.5	-0.9	-1.4	-1.8	-2.1	-2.5	
Difference	0.0	0.0	-0.5	-0.9	-1.4	-1.8	-2.1	-2.5	-9.1
Net Mandatory Outlays									
Current Law	157.7	178.3	197.1	215.6	237.0	260.4	286.1	314.7	
Proposed Law	157.7	169.5	180.3	190.2	200.4	212.4	225.8	240.2	
Change in Net Medicare Outlays	0.0	-8.8	-16.8	-25.4	-36.6	-47.9	-60.4	-74.6	-270.3

135.4

DRAFT

SEP-24-95 18:07 FROM: ID: PAGE 3/4

09-25-95 05:00PM FOO3 #10

Medicare Proposal (based on specs through 9/24): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total

DRAFT

FOOTNOTES:

/1 Update assumed to be market basket -2.5 percentage points.
/2 Reflects payments to facilities providing services to Medicare Choice beneficiaries.
/3 No Medicaid offset taken on the assumption that the program will become a block grant.
/4 Assumes that legislative language would meet scorekeeping requirements.

NOTES:

ESTIMATES BASED ON CHAIRMAN'S MARK AND DISCUSSIONS WITH COMMITTEE STAFF

1. These estimates assume an enactment date of November 15, 1995. The estimates would change if the proposal was enacted at a later date.
2. These estimates are based on preliminary specifications, not legislative language.
3. The estimates do not take into account the "BELT" budget control mechanism.
4. The effects of medical savings acount provision are embodied in the Medicare Choice line. Possible interactions between FEHBP and the MSA provision are not reflected in this estimate.
5. To the extent that health care providers are able to offset lower reimbursements by shifting costs to other payers, federal revenues could fall.
6. These estimates do not incorporate changes in discretionary spending for administration.

DRAFT

CHART 3 -- MEDICAID

[TO BE SUPPLIED]

CHART 4 -- EITC REFORMS

Earned Income Tax Credit Reform Package
Senate Finance Committee

[Millions of Dollars]

Item	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY1996-00	FY1996-02
Package of several EITC changes including: maximum 36% credit; modified AGI; broaden disqualified income; repeal childless EITC; compliance proposals; and 0.82% for one child and 0.82% for two children phaseout of EITC per $100 over phaseout income.									
Total Effect:	266	5,350	5,997	6,658	7,367	8,061	8,736	25,638	42,435
Outlay Reduction:	214	4,305	4,716	5,150	5,661	6,059	6,380	20,045	32,485

Modified AGI for the purpose of the phaseout of the EITC would be defined to include: nontaxable Social Security benefits; nontaxable distributions from IRA's, pensions, and annuities; the addback of losses from Schedule C, Schedule D, Schedule E, Schedule F, and net operating losses; tax-exempt interest; and child support payments.

Disqualified income would be expanded to include: net capital gains (if positive) and net passive income (if positive).

Maximum 36% credit rate for taxpayers with two or more qualifying children.

Compliance proposals: require S.S. numbers for primary and secondary taxpayers; the omission of a correct S.S. number treated as a math error; double civil penalties and permit a heighten review process for tax-return preparers of EITC returns; and math-error procedure for EITC recipients who fail to pay the proper self-employment tax.

Repeal the EITC for childless workers.

Phase out the EITC by reducing the credit by a specified percentage for each $100 of income over the phaseout income amount. Phaseout rates are 0.82% per $100 for taxpayers with one qualifying child and 0.82% for taxpayers with two or more qualifying children.

Preliminary Estimate:
8/20/95

CHART 5 – TITLE XX

Preliminary CBO Estimate **07/24/95**
(by fiscal year in millions of dollars)

D-R-A-F-T

	1996	1997	1998	1999	2000	2001	2002	5-year Total	7-year Total
Proposal: Reduce Social Services Block Grant by 20%									
Budget Authority	-560	-560	-560	-560	-560	-560	-560	-2800	-3920
Outlays	-505	-560	-560	-560	-560	-560	-560	-2745	-3865

NOTES: These are preliminary CBO staff estimates.
Assumes November 15, 1995 effective date.

CHART 6 – FOSTER CARE ADMIN. COSTS

09/22/95 02:32 PM

Foster Care budget options for the Senate Finance Committee
Assumes November 15, 1995 effective date.
D-R-A-F-T
Compared to CBO baseline

(by fiscal year, outlays in millions of dollars)

		1996	1997	1998	1999	2000	2001	2002	Five-Year Total	Seven-Year Total
Direct Spending										
Reduce growth of foster care administrative costs to 10% a year a\	BA	-90	-190	-200	-230	-250	-270	-280	-960	-1510
	OT	-70	-180	-200	-220	-250	-270	-280	-920	-1470

This is a preliminary estimate.
a\ This assumes that the 10% cap in growth of administrative costs each year (not applicable to computer purchases) would apply to each state.

CHART 7 – CHILD SUPPORT ENFORCEMENT FEES

PRELIMINARY ESTIMATE OF CHILD SUPPORT FEE
Assumes November 15, 1995 Effective Date

09/21/95

Outlays by fiscal year, in million of dollars

	1996	1997	1998	1999	2000	2001	2002	7-Year Total
Require states to charge non-AFDC families a 10 percent fee on any child support collected for them and a mandatory $25 application fee								
Family Support	-395	-500	-540	-580	-630	-680	-730	-4,055
Food Stamps	30	35	40	40	45	50	50	285
Total	-370	-465	-500	-540	-585	-630	-680	-3,770

Basis of Estimate

The proposed policy would require states to charge non-AFDC families who receive IV-D services a fee of $25 at the time they apply for services and a fee equal to 10 percent of any child support collected for them. The federal government would save $3.8 billion through FY 2002 at the current federal matching rate of 66 percent. States would be given the flexibility to charge the fee either to the custodial or non-custodial parent; to exempt low-income families, but charge more to higher-income families; or to impose no fee at all. However, the state would have to pay the federal government its share of the fee as if the $25 and 10% policy was in effect.

This estimate assumes that states would have to implement the fee collection system by 11/15/95 (very unlikely that states would be able to do so) or pay the federal share of the new fees on behalf of the non-AFDC family until the state had a program in place. If an implementation period is allowed before the law takes effect, fiscal year 1996 savings will be lower.

ANNUAL GROWTH RATES UNDER FINANCE COMMITTEE MEDICAID FORMULA

STATE	1996	1997	1998	1999	2000	2001	2002
Alabama	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Alaska	7.25	8.44	4.91	4.42	4.42	4.42	4.42
Arizona	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Arkansas	7.25	8.44	5.53	5.53	5.53	5.53	5.53
California	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Colorado	7.25	8.44	5.53	5.53	5.53	4.20	4.20
Connecticut	7.25	2.00	2.00	2.00	2.00	2.00	2.00
Delaware	7.25	6.61	4.42	4.42	4.42	4.42	4.42
DC	7.25	2.00	2.00	2.00	2.00	2.00	2.00
Florida	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Georgia	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Hawaii	7.25	2.26	2.00	2.00	2.00	2.00	2.00
Idaho	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Illinois	7.25	8.44	5.53	5.53	5.32	4.20	4.20
Indiana	7.25	8.44	5.53	5.53	5.53	5.46	5.10
Iowa	7.25	8.44	5.53	5.53	4.20	4.20	4.20
Kansas	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Kentucky	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Louisiana	7.25	0.00	0.00	0.00	0.00	5.53	5.53
Maine	7.25	8.44	4.20	4.20	4.20	4.20	4.20
Maryland	7.25	8.44	4.20	4.20	4.20	4.20	4.20
Massachusetts	7.25	2.00	2.00	2.00	2.00	2.00	2.00
Michigan	7.25	8.44	5.53	5.53	5.53	4.20	4.20
Minnesota	7.25	8.44	4.20	4.20	4.20	4.20	4.20
Mississippi	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Missouri	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Montana	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Nebraska	7.25	8.44	4.20	4.20	4.20	4.20	4.20
Nevada	7.25	8.44	5.53	5.53	5.53	5.53	5.53
New Hampshire	7.25	0.00	0.00	0.00	2.00	2.00	2.00
New Jersey	7.25	7.79	4.20	4.20	4.20	4.20	4.20
New Mexico	7.25	8.44	5.53	5.53	5.53	5.53	5.53
New York	7.25	2.00	2.00	2.00	2.00	2.00	2.00
North Carolina	7.25	8.44	5.53	5.53	5.53	5.53	5.53
North Dakota	7.25	8.44	5.53	5.53	5.53	4.20	4.20
Ohio	7.25	8.44	4.50	4.20	4.20	4.20	4.20
Oklahoma	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Oregon	7.25	8.44	5.53	4.67	4.20	4.20	4.20
Pennsylvania	7.25	8.44	4.20	4.20	4.20	4.20	4.20
Rhode Island	7.25	2.00	2.00	2.00	2.00	2.00	2.00
South Carolina	7.25	8.44	5.53	5.53	5.53	5.53	5.53
South Dakota	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Tennessee	7.25	8.44	5.53	5.53	5.53	5.44	5.10
Texas	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Utah	7.25	8.44	5.53	5.53	5.53	5.53	5.40
Vermont	7.25	2.00	2.00	2.00	2.00	2.00	2.00
Virginia	7.25	8.44	5.53	5.53	5.53	5.53	5.53
Washington	7.25	2.00	2.00	2.00	2.00	2.00	2.00
West Virginia	7.25	8.44	5.53	5.53	5.14	4.20	4.20
Wisconsin	7.25	8.44	5.53	5.53	5.53	4.20	4.20
Wyoming	7.25	8.44	5.53	5.53	5.53	5.53	5.53
NATIONAL	7.25	6.75	4.42	4.42	4.42	4.42	4.42

FY 1994 Medicaid Federal Grants Per Person in Poverty

State	Amount	Rank
Alabama	1,732	41
Alaska	2,860	11
Arizona	1,980	37
Arkansas	1,861	39
California	1,453	48
Colorado	1,749	40
Connecticut	4,226	2
Delaware	2,549	17
District of Columbi	3,224	7
Florida	1,357	50
Georgia	2,013	35
Hawaii	2,294	24
Idaho	1,539	47
Illinois	1,683	43
Indiana	2,474	19
Iowa	2,452	20
Kansas	2,000	36
Kentucky	1,887	38
Louisiana	3,153	8
Maine	3,407	6
Maryland	2,401	22
Massachusetts	3,936	4
Michigan	2,176	25
Minnesota	2,646	14
Mississippi	1,662	44
Missouri	2,040	32
Montana	2,070	31
Nebraska	2,443	21
Nevada	1,378	49
New Hampshire	5,077	1
New Jersey	3,009	9
New Mexico	1,567	46
New York	3,854	5
North Carolina	2,132	28
North Dakota	2,649	13
Ohio	2,374	23
Oklahoma	1,311	51
Oregon	2,034	33
Pennsylvania	2,696	12
Rhode Island	4,095	3
South Carolina	2,155	26
South Dakota	2,085	30
Tennessee	2,146	27
Texas	1,715	42
Utah	2,025	34
Vermont	2,915	10
Virginia	1,633	45
Washington	2,643	15
West Virginia	2,598	16
Wisconsin	2,537	18
Wyoming	2,113	29
Total	2,188	–

Note: Grant amounts are the larger of lines 6 (scaled) or line 11.

FINANCE COMMITTEE MEDICAID FORMULA SIMULATION

Summary of State Changes from 1997 to 2002 with Ceiling of 125 Percent of the National Average Growth (7.25, 6.75, 4.424) and a Floor of (2, 2, 2, 2, 2, & 2) Percent
Revised Baseline Data Set using FY 95 Grant Est. Incl 9% DSH; Official Poverty; small state minimum = 0.21% and the Larger of FY94 or 95 Medicaid Payments

State	Federal Medicaid Esitmated Grant FY 1995 (incl. DSH)	Projected Federal Medicaid Grant FY 1996	Alternative Federal Medicaid Grant FY 1997	% Differ-Ence	Alternative Federal Medicaid Grant FY 1998	% Differ-Ence	Alternative Federal Medicaid Grant FY 1999	% Differ-Ence	Alternative Federal Medicaid Grant FY 2000	% Differ-Ence	Alternative Federal Medicaid Grant FY 2001	% Differ-Ence	Alternative Federal Medicaid Grant FY 2002	% Differ-Ence	Total Federal Medicaid Grant FY 1996 - 2002
Alabama	1,232,747,548	1,323,416,231	1,435,079,475	8.44	1,514,439,370	5.53	1,598,187,887	5.53	1,686,567,856	5.53	1,779,834,848	5.53	1,878,259,715	5.53	11,215,785,162
Alaska	180,386,150	193,653,566	209,993,085	8.44	220,301,311	4.91	230,047,441	4.42	240,224,740	4.42	250,852,282	4.42	261,949,987	4.42	1,607,022,412
Arizona	1,141,548,640	1,225,509,635	1,328,912,011	8.44	1,402,400,845	5.53	1,479,953,612	5.53	1,561,795,047	5.53	1,648,162,313	5.53	1,739,305,689	5.53	10,386,039,151
Arkansas	903,566,767	970,024,176	1,051,869,966	8.44	1,110,038,375	5.53	1,171,423,497	5.53	1,236,203,216	5.53	1,304,565,254	5.53	1,376,707,713	5.53	8,220,832,196
California	8,997,621,476	9,659,397,268	10,474,406,913	8.44	11,053,643,726	5.53	11,664,910,224	5.53	12,309,979,759	5.53	12,990,721,640	5.53	13,709,108,546	5.53	81,862,170,076
Colorado	759,406,285	815,260,679	884,048,298	8.44	932,936,169	5.53	984,527,540	5.53	1,038,971,912	5.53	1,082,608,733	4.20	1,128,078,300	4.20	6,866,431,631
Connecticut	1,183,457,184	1,270,500,556	1,295,910,567	2.00	1,321,828,778	2.00	1,348,265,354	2.00	1,375,230,661	2.00	1,402,735,274	2.00	1,430,789,980	2.00	9,445,261,171
Delaware	184,329,398	197,886,840	210,968,083	6.61	220,301,311	4.42	230,047,441	4.42	240,224,740	4.42	250,852,282	4.42	261,949,987	4.42	1,612,230,684
District of Columbia	473,242,450	508,049,471	518,210,460	2.00	528,574,669	2.00	539,146,163	2.00	549,929,066	2.00	560,927,868	2.00	572,146,221	2.00	3,778,983,737
Florida	3,492,519,400	3,749,394,485	4,065,749,645	8.44	4,290,585,600	5.53	4,527,854,984	5.53	4,778,245,365	5.53	5,042,482,333	5.53	5,321,331,606	5.53	31,775,644,020
Georgia	2,214,274,691	2,377,134,774	2,577,705,521	8.44	2,720,252,636	5.53	2,870,682,607	5.53	3,029,431,355	5.53	3,196,958,909	5.53	3,373,750,736	5.53	20,145,916,537
Hawaii	308,112,537	330,774,239	338,258,770	2.26	345,023,945	2.00	351,924,424	2.00	358,962,912	2.00	366,142,171	2.00	373,465,014	2.00	2,464,551,475
Idaho	258,469,554	277,480,011	300,892,387	8.44	317,531,736	5.53	335,091,241	5.53	353,621,787	5.53	373,177,072	5.53	393,813,764	5.53	2,351,607,998
Illinois	3,358,716,225	3,605,750,076	3,909,885,239	8.44	4,126,207,423	5.53	4,354,386,693	5.53	4,586,017,845	5.32	4,778,630,594	4.20	4,979,333,079	4.20	30,340,310,948
Indiana	1,592,560,484	1,709,693,437	1,853,948,821	8.44	1,956,472,191	5.53	2,064,665,103	5.53	2,178,841,083	5.53	2,297,786,568	5.46	2,414,864,164	5.10	14,476,271,386
Iowa	748,250,363	803,284,238	871,061,345	8.44	919,231,038	5.53	970,064,514	5.53	1,010,807,224	4.20	1,053,261,127	4.20	1,097,498,094	4.20	6,725,207,579
Kansas	577,887,823	620,391,520	672,737,054	8.44	709,939,413	5.53	749,199,063	5.53	790,629,771	5.53	834,351,597	5.53	880,491,240	5.53	5,257,739,657
Kentucky	1,475,600,195	1,584,130,710	1,717,791,738	8.44	1,812,765,621	5.53	1,913,032,666	5.53	2,018,823,373	5.53	2,130,464,305	5.53	2,248,278,981	5.53	13,425,307,395
Louisiana	2,493,040,670	2,600,000,000	2,600,000,000	0.00	2,600,000,000	0.00	2,600,000,000	0.00	2,600,000,000	0.00	2,743,780,000	5.53	2,895,511,034	5.53	18,639,291,034
Maine	571,970,406	614,038,876	665,848,406	8.44	693,814,039	4.20	722,954,229	4.20	753,318,306	4.20	784,957,675	4.20	817,925,898	4.20	5,052,857,429
Maryland	1,351,796,165	1,451,220,882	1,573,667,644	8.44	1,639,761,685	4.20	1,708,631,676	4.20	1,780,394,207	4.20	1,855,170,763	4.20	1,933,087,935	4.20	11,941,934,793
Massachusetts	2,488,902,175	2,671,961,132	2,725,400,354	2.00	2,779,906,361	2.00	2,835,506,529	2.00	2,892,216,659	2.00	2,950,060,992	2.00	3,009,062,212	2.00	19,864,116,240
Michigan	3,037,158,972	3,260,542,261	3,535,650,515	8.44	3,731,171,968	5.53	3,937,505,799	5.53	4,155,249,870	5.53	4,329,770,364	4.20	4,511,620,719	4.20	27,481,511,516
Minnesota	1,544,616,455	1,658,223,121	1,798,135,696	8.44	1,873,657,396	4.20	1,952,351,006	4.20	2,034,349,748	4.20	2,119,792,438	4.20	2,208,823,720	4.20	13,645,333,125
Mississippi	1,251,826,104	1,343,898,015	1,457,269,411	8.44	1,537,877,515	5.53	1,622,922,142	5.53	1,712,669,736	5.53	1,807,380,372	5.53	1,907,328,507	5.53	11,389,365,698
Missouri	1,410,019,072	1,513,726,089	1,641,446,728	8.44	1,732,218,732	5.53	1,828,010,428	5.53	1,929,099,404	5.53	2,035,778,601	5.53	2,148,357,158	5.53	12,828,637,140
Montana	270,497,728	290,392,857	314,894,755	8.44	332,306,435	5.53	350,685,091	5.53	370,077,977	5.53	390,543,289	5.53	412,140,333	5.53	2,461,042,735
Nebraska	425,102,423	456,368,741	494,874,854	8.44	515,659,597	4.20	537,317,301	4.20	559,884,627	4.20	583,399,782	4.20	607,902,572	4.20	3,755,407,474
Nevada	225,200,494	241,764,009	262,162,847	8.44	276,680,452	5.53	291,959,775	5.53	308,105,151	5.53	325,143,368	5.53	343,123,794	5.53	2,048,919,393
New Hampshire	349,995,282	360,000,000	360,000,000	0.00	360,000,000	0.00	360,000,000	0.00	367,200,000	2.00	374,544,000	2.00	382,034,880	2.00	2,563,778,880
New Jersey	2,374,269,331	2,548,897,034	2,747,578,083	7.79	2,862,976,362	4.20	2,983,221,370	4.20	3,108,516,667	4.20	3,239,074,387	4.20	3,375,115,491	4.20	20,865,379,374
New Mexico	599,158,116	643,226,244	697,498,458	8.44	736,070,123	5.53	776,774,800	5.53	819,730,447	5.53	865,061,541	5.53	912,899,444	5.53	5,451,261,056
New York	12,288,725,546	13,192,562,308	13,456,413,554	2.00	13,725,541,825	2.00	14,000,052,662	2.00	14,280,053,715	2.00	14,565,654,790	2.00	14,856,967,885	2.00	98,077,246,740
North Carolina	2,274,613,104	2,441,911,082	2,647,947,330	8.44	2,794,378,817	5.53	2,948,907,966	5.53	3,111,982,576	5.53	3,284,075,213	5.53	3,465,684,572	5.53	20,694,887,556
North Dakota	215,749,849	231,618,268	251,161,060	8.44	265,050,266	5.53	279,707,546	5.53	295,175,373	5.53	307,572,739	4.20	320,490,794	4.20	1,950,778,045
Ohio	3,829,476,613	4,111,134,929	4,458,011,939	8.44	4,658,615,150	4.50	4,854,276,988	4.20	5,058,156,620	4.20	5,270,599,198	4.20	5,491,964,384	4.20	33,902,759,186
Oklahoma	840,929,355	902,779,777	978,951,821	8.44	1,033,087,856	5.53	1,090,217,615	5.53	1,150,506,649	5.53	1,214,129,668	5.53	1,281,271,037	5.53	7,650,944,420
Oregon	989,494,148	1,062,271,523	1,151,900,683	8.44	1,215,600,790	5.53	1,272,414,785	4.67	1,325,856,206	4.20	1,381,542,166	4.20	1,439,566,937	4.20	8,849,153,090
Pennsylvania	4,077,959,109	4,377,893,333	4,747,278,083	8.44	4,948,683,763	4.20	5,154,423,641	4.20	5,370,909,433	4.20	5,596,487,830	4.20	5,831,540,110	4.20	36,025,195,992
Rhode Island	541,809,154	581,659,261	593,292,446	2.00	605,158,295	2.00	617,261,461	2.00	629,606,690	2.00	642,198,824	2.00	655,042,801	2.00	4,324,219,779
South Carolina	1,351,650,201	1,451,064,183	1,573,497,724	8.44	1,660,512,148	5.53	1,752,338,470	5.53	1,849,242,787	5.53	1,951,505,913	5.53	2,059,424,190	5.53	12,297,585,414
South Dakota	235,192,747	252,491,192	273,795,137	8.44	288,938,008	5.53	304,914,169	5.53	321,775,922	5.53	339,570,131	5.53	358,348,359	5.53	2,139,830,917
Tennessee	2,245,684,261	2,410,833,050	2,614,247,069	8.44	2,758,814,953	5.53	2,911,377,420	5.53	3,072,376,591	5.53	3,239,452,811	5.44	3,404,510,267	5.10	20,411,611,981
Texas	5,383,536,018	5,779,495,529	6,267,140,464	8.44	6,613,713,332	5.53	6,979,451,679	5.53	7,365,415,357	5.53	7,772,722,826	5.53	8,202,554,399	5.53	48,980,493,587
Utah	448,048,181	481,002,161	521,586,718	8.44	550,430,463	5.53	580,869,268	5.53	612,991,339	5.53	646,889,760	5.53	681,848,131	5.40	4,075,617,839
Vermont	222,666,479	239,043,617	243,824,489	2.00	248,700,979	2.00	253,674,998	2.00	258,748,498	2.00	263,923,468	2.00	269,201,938	2.00	1,777,117,986
Virginia	1,092,857,046	1,173,236,771	1,272,228,623	8.44	1,342,582,886	5.53	1,416,827,699	5.53	1,495,178,270	5.53	1,577,861,629	5.53	1,665,117,377	5.53	9,943,033,234
Washington	1,581,626,214	1,697,954,951	1,731,914,050	2.00	1,766,552,331	2.00	1,801,883,378	2.00	1,837,921,045	2.00	1,874,679,466	2.00	1,912,173,055	2.00	12,823,078,276
West Virginia	1,009,081,439	1,083,299,461	1,174,702,853	8.44	1,239,663,921	5.53	1,308,217,336	5.53	1,375,486,204	5.14	1,433,256,825	4.20	1,493,453,403	4.20	9,108,079,802
Wisconsin	1,531,224,596	1,643,846,290	1,782,545,820	8.44	1,881,120,604	5.53	1,985,146,573	5.53	2,094,925,179	5.53	2,162,912,036	4.20	2,274,594,342	4.20	13,845,090,845
Wyoming	110,445,376	118,568,642	128,572,871	8.44	135,682,951	5.53	143,186,218	5.53	151,104,416	5.53	159,460,491	5.53	168,278,656	5.53	1,004,854,246
U. S. Total	87,747,000,000	94,108,657,500	100,460,991,881	6.75	104,905,386,162	4.42	109,548,400,446	4.42	114,392,733,202	4.42	119,453,467,718	4.42	124,738,089,130	4.42	767,605,726,040

States exceeding 6.75% growth in FY 1997 = 40

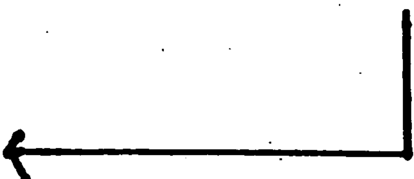
Expenditure Needs Medicaid Formula Proposal

States	Poverty Count	Medicaid Case Mix Cost Index	Health Care Cost Index	US Average Benefit per Person in Poverty	Expenditure Needs	Current FMAP FY'94	Initial Grant Calculation
Alabama	742,000	1.19	0.83	$3,795	$2,788,407,658	0.7122	$1,985,903,934
Alaska	55,667	0.74	1.25	$3,795	$194,524,912	0.5000	$97,262,456
Arizona	567,000	0.77	0.98	$3,795	$1,621,074,012	0.6590	$1,068,287,774
Arkansas	444,333	1.27	0.80	$3,795	$1,711,946,601	0.7446	$1,274,715,439
California	5,184,333	0.94	1.22	$3,795	$22,400,285,522	0.5000	$11,200,142,761
Colorado	351,333	0.99	0.97	$3,795	$1,293,116,538	0.5430	$702,162,280
Connecticut	289,000	1.08	1.18	$3,795	$1,396,105,468	0.5000	$698,052,734
Delaware	60,333	0.89	1.03	$3,795	$210,338,875	0.5000	$105,169,439
District of Columbia	121,333	0.93	1.18	$3,795	$504,553,570	0.5000	$252,276,785
Florida	2,224,333	0.98	0.95	$3,795	$7,896,399,991	0.5478	$4,325,100,115
Georgia	1,049,000	0.98	0.92	$3,795	$3,577,925,252	0.6247	$2,235,129,905
Hawaii	103,333	0.98	1.11	$3,795	$418,324,652	0.5000	$209,162,326
Idaho	151,333	0.91	0.88	$3,795	$458,887,504	0.7092	$325,443,018
Illinois	1,678,000	0.97	0.99	$3,795	$6,060,996,332	0.5000	$3,030,498,166
Indiana	743,333	0.91	0.93	$3,795	$2,373,307,238	0.6349	$1,506,812,765
Iowa	298,000	1.02	0.85	$3,795	$979,895,175	0.6333	$620,567,614
Kansas	307,000	0.95	0.89	$3,795	$989,095,272	0.5952	$588,709,506
Kentucky	723,000	1.13	0.87	$3,795	$2,684,627,056	0.7091	$1,903,669,045
Louisiana	978,000	1.10	0.89	$3,795	$3,648,352,376	0.7349	$2,681,174,161
Maine	179,000	1.10	0.92	$3,795	$692,731,906	0.6196	$429,216,689
Maryland	493,000	1.07	1.00	$3,795	$1,991,626,556	0.5000	$995,813,278
Massachusetts	619,333	1.17	1.13	$3,795	$3,108,244,021	0.5000	$1,554,122,010
Michigan	1,345,667	0.94	1.04	$3,795	$5,012,027,163	0.5637	$2,825,279,723
Minnesota	541,333	1.08	1.00	$3,795	$2,180,867,156	0.5465	$1,191,843,901
Mississippi	644,667	1.15	0.74	$3,795	$2,097,609,997	0.7885	$1,653,965,483
Missouri	789,667	1.00	0.90	$3,795	$2,705,754,140	0.6064	$1,640,769,311
Montana	122,333	0.98	0.87	$3,795	$387,708,051	0.7105	$275,465,149
Nebraska	165,000	0.98	0.91	$3,795	$558,923,396	0.6198	$346,181,120
Nevada	156,667	0.98	1.10	$3,795	$637,339,649	0.5031	$320,645,578
New Hampshire	97,333	1.16	1.02	$3,795	$436,582,118	0.5000	$218,291,059
New Jersey	7?7,000	1.03	1.10	$3,795	$3,429,608,174	0.5000	$1,714,804,087
New Mexico	319,333	0.85	0.93	$3,795	$956,804,240	0.7417	$709,661,705
New York	2,806,333	1.03	1.21	$3,795	$13,270,106,814	0.5000	$6,635,053,407
North Carolina	992,333	0.97	0.90	$3,795	$3,282,799,179	0.6514	$2,138,415,385
North Dakota	78,333	1.10	0.86	$3,795	$282,031,261	0.7113	$200,608,836
Ohio	1,443,333	0.97	0.95	$3,795	$5,044,969,860	0.6083	$3,068,855,166
Oklahoma	601,000	1.00	0.83	$3,795	$1,891,088,067	0.7039	$1,331,136,891
Oregon	368,000	0.92	1.04	$3,795	$1,336,488,117	0.6212	$830,226,418
Pennsylvania	1,454,667	1.10	1.01	$3,795	$6,159,347,976	0.5461	$3,363,619,929
Rhode Island	107,667	1.23	1.08	$3,795	$540,436,649	0.5387	$291,133,223
South Carolina	649,000	1.15	0.88	$3,795	$2,481,052,791	0.7108	$1,763,532,324
South Dakota	101,000	1.07	0.81	$3,795	$330,762,867	0.6950	$229,880,207
Tennessee	863,667	1.11	0.88	$3,795	$3,221,493,871	0.6715	$2,163,233,134
Texas	3,073,667	0.90	0.92	$3,795	$9,623,684,650	0.6418	$6,176,480,808
Utah	195,667	0.77	0.96	$3,795	$548,144,229	0.7435	$407,545,234
Vermont	65,000	0.97	0.94	$3,795	$225,706,634	0.5955	$134,407,705
Virginia	606,333	1.02	0.91	$3,795	$2,136,309,244	0.5000	$1,068,154,622
Washington	554,333	0.91	1.04	$3,795	$1,987,463,761	0.5424	$1,078,000,344
West Virginia	374,333	1.01	0.85	$3,795	$1,219,302,186	0.7572	$923,255,615
Wisconsin	559,667	1.20	0.91	$3,795	$2,316,453,901	0.6047	$1,400,759,674
Wyoming	53,333	0.87	0.83	$3,795	$146,762,644	0.6563	$96,320,323
U.S.	37,285,667	1.00	1.00	$3,795	$141,499,105,000		$81,985,918,560

Proposed Medicaid Formula

$$\text{Caseload Cost Index} = \frac{\$8596 \cdot \text{P65}^{*}\ \text{Share} + \$7816 \cdot \text{B\&D Share} + \$1298 \cdot \text{Other Share}}{\$3171}$$

$$\text{State Grant} = \begin{pmatrix}\text{U.S. Spending}\\ \text{Per Person in}\\ \text{Poverty}\end{pmatrix} \cdot \begin{pmatrix}\text{Caseload}\\ \text{Cost}\\ \text{Index}\end{pmatrix} \cdot \begin{pmatrix}\text{Input}\\ \text{Cost}\\ \text{Index}\end{pmatrix} \cdot \begin{pmatrix}\text{Poverty}\\ \text{Count}\end{pmatrix} \cdot \begin{pmatrix}\text{Federal}\\ \text{Medical}\\ \text{Assistance}\\ \text{Percentage}\end{pmatrix} \cdot \begin{pmatrix}\text{Adjustment}\\ \text{Factor}\end{pmatrix}$$



$$\text{Input Cost Index} = 0.15 + 0.85 \cdot \begin{pmatrix}\text{PPS}\\ \text{Wage}\\ \text{Index}\end{pmatrix}$$

$$\text{FMAP} = 1.0 - 0.45\left(\frac{\text{State Per Capita Income}}{\text{U.S. Per Capita Income}}\right)^2$$

STATEMENT BY SEN. BOB GRAHAM
SENATE FINANCE COMMITTEE
SEPTEMBER 26, 1995

Thirty years ago, President Johnson signed the law creating the Medicare and Medicaid programs. At a ceremony in Independence, Missouri, President Johnson issued former President Harry S. Truman the first Medicare identification card in recognition of President Truman's early effort to create the national health care program for elderly Americans.

Supporters of guaranteed health care for the elderly and poor in our nation rejoiced at the establishment of Medicare and Medicaid. For example, thirty years ago, America's elderly and poor were in dire need of health coverage. A 1962 National Health Survey showed that three-fourths of all seniors not in institutions suffered from one or more chronic conditions. Forty percent of the aged had a chronic condition that prevented or severely limited their activity. Twenty percent of the aged were either confined to their homes or needed help getting around.

Medicare and Medicaid have changed all of that for the elderly, disabled and poor. These two programs have played a large role in the significant improvements in a variety of key health status indicators, such as infant mortality and life expectancy at 65 years of age that has occurred since 1965.

Quality of life. Today, Medicare provides 33 million Americans over age 65 and 4 million people with disabilities the security of guaranteed quality health care. Medicaid covers 33% of all births, 25% of all children and is the primary payer of nursing home services.

Improved health status. While the quality of life for elderly, disabled and the poor

has improved since the implementation of Medicare and Medicaid, so has their health status. Life expectancy in Florida has risen from 69.8 years in 1960 to 76.6 years in 1994. The number of people in Florida over age 85 in 1960 was 10,500. Today it's more than 270,000 -- nearly 2 percent of the State population.

Moreover, the infant mortality rate in Florida decreased 19% between 1984 and 1992 -- from 10.8 to 8.8 per 1000 live births.

Nationally, according to an article by Nancy De Lew in the July 19, 1995, issue of The Journal of the American Medical Association, "Medicaid coverage has improved birth outcomes, childhood immunization rates, access to well-child preventive services, and the health of children."

Better health and longer life for Americans is attributable in large part to Medicare and Medicaid, but what ought to be a celebration of their success has instead become an occasion of anxiety and apprehension. Despite these successes, the word "entitlement" has become an extreme pejorative.

These programs, which serve as the nation's safety net, have become victims of their own success. Their strongest opponents use any measure which appears to create an individual right to federal funds as heresy. Previous advocates of entitlement have dropped the word in favor of "guarantee".

Balance must be achieved between the health status of our nation's people and restraining health care costs. Cost containment can certainly be accomplished without totally threatening these health programs and has been done in the past. Modernization and moderation are the answers.

In should be noted that the changes enacted to the Medicare program during the

Reagan Administration were successful at maintaining coverage while slowing the rate of increase in spending. In fact, for 8 out of 10 years ending in 1993, Medicaid had a lower per-person growth rate than private plans.

Radical cuts are not the solution, particularly to fund tax breaks for the wealthy. Unfortunately, the proposals before us reduces an unprecedented $452 billion from anticipated Medicare and Medicaid expenditures over the next seven years.

This plan resembles the old "bait and switch"....

It does so by threatening the contract and commitment that our country made to the elderly of this nation in ensuring their health coverage. It also does so by slashing huge holes in our nation's safety net for the uninsured and poor. Access and quality are put at tremendous risk by this proposal.

According to the Congressional Budget Office, the Republican plan would limit Medicare and Medicaid spending to increases of 4.9 and 1.4 percent and year per recipient. By contrast, private health care spending is projected to increase 7.1 percent a year per person. This budget proposal is clearly unrealistic, unfair and undeserving of support.

Instead, we should keep our contract with the elderly and work to extend the Trust Fund through the next decade with one-third of the cuts contemplated by the plan before us. Medicare has lived up to its promise and should not be recklessly tampered with, as contemplated by the proposal before us.

In addition, we should tread very carefully with the radical changes offered in the Medicaid program through a block grant. A recent report by the Kaiser Foundation for the

Future of Medicaid estimates the block grant proposal will cause 8.9 million Americans to lose health coverage. That is a 19.5 percent reduction in the projected number of Medicaid beneficiaries for that year.

That would bring the total number of uninsured Americans to more than 50 million, placing tremendous additional pressure on our nation's health care system, further complicating efforts to balance the budget, and creating an enormous cost shift to state and local governments.

For states, this will be the "great white shark". Overwhelmed by increasing costs, no federal recognition of either economic or demographic changes and the cost of treating people with chronic illness, states will have the Hobson's choice of denying treatment for pre-existing conditions, establishing lower eligibility standards for all, or flatly denying coverage for certain conditions such as AIDS. Children will be highly at risk.

As the General Accounting Office said in its July 1995 report entitled Medicaid and Uninsured Children, "Changes to the Medicaid program that remove guaranteed eligibility and change the financing and responsibilities of the federal and state governments may strongly affect health insurance coverage for children in the future. Children account for only a small portion of Medicaid costs. Because they represent almost half the participants, however, any changes to Medicaid disproportionately affect children. Changes to Medicaid that result in reducing the number of children covered, without any accompanying changes in the health insurance marketplace either to encourage employers to provide dependent health insurance coverage, or to encourage families to purchase insurance, or to provide other coverage options for children, could lead to a significantly increased number of uninsured children in the future."

The federal guarantee for our nation's most vulnerable populations does not have to be removed to control costs in Medicaid. Instead, the program could be disciplined by limited annual growth in federal spending per beneficiary. Ironically, this option -- otherwise known as a "per capita cap" -- was included in health reform proposals introduced by Sens. Bob Dole, Bob Packwood, Phil Gramm and John Chafee in 1994. Fortunately, Sen. Chafee is once again considering this important alternative and compromise to block grants. I urge members to support his bipartisan effort.

As Emily Friedman wrote in The Journal of the American Medical Association, "So far, we have been unable, as a nation, to come up with better means of addressing the basic, visceral human troubles that Medicare and Medicaid seek to alleviate; until we do, these programs remain the best answers we have. And their underlying mission remains necessary, even as they are reconfigured, as they have been so often. For no matter how many times they have failed, they have accomplished much; and it is painful to contemplate the burden of suffering that Americans would have borne without their protection."

These proposals to radically overhaul what has been successful Medicare and Medicaid programs come before us without hearings and debate. Many questions remain unanswered.

For the Record

OPENING STATEMENT
SENATOR DAVID PRYOR

Committee on Finance

September 26, 1995

David Pryor

To be honest, Mr. Chairman, I feel somewhat overwhelmed by just the thought of the task before us -- and I'm finding it hard to comprehend the full impact of the proposal we are considering. Today this Committee will attempt to cut expected outlays in the Medicare program by $270 billion, and Medicaid by $182 billion. At the same time, or very shortly thereafter, we will also be discussing a $245 billion tax cut. As many changes as I have seen this panel enact in the twelve years that I have served on it, I don't believe that any action we have taken to date compares to the magnitude of the proposal before us.

Medicare

Simply put, this proposal would make sweeping changes and seriously alter the Medicare program as we know it. While it is clear that changes are needed in this program, I believe it is our duty to ensure that those changes are made in a responsible manner, and that older and disabled Americans can

continue to rely with confidence on the health security provided under this program.

Unfortunately, while this proposal is intended to encourage more seniors to enroll in so-called managed care plans, it appears that the plan may be less than adequate in terms of providing beneficiary protections. In fact, while I've not seen the legislative language, it appears that the plan may actually eliminate some protections currently available to beneficiaries under present law. This could lead to beneficiaries moving AWAY from managed care plans, rather than the other way around. It would be very short-sighted of us to reduce protections at a time when we're trying to encourage expanded coverage. I would urge that we take steps to ensure that the bill we report out of this Committee will more adequately address these concerns.

Medicaid

I also have grave concerns about many of the changes that this proposal would make to the Medicaid program. In addition to making unprecedented cuts, the proposal eliminates many of the conditions states must currently meet in exchange for generous Federal funding.

We can all agree that the Medicaid program is not perfect. In fact, many of us on this Committee have spent a good deal of time over the last

few years trying to improve this program. I am concerned, however, that this proposal to block grant Medicaid and cut Medicaid spending would have devastating consequences for those who rely on the program for their health and long-term care.

I have some very broad concerns about the impact of the cuts generally. But beyond those concerns, the proposal would also make some very specific changes to Medicaid which I believe to be ill-advised and, in some cases, dangerous.

Specifically, I am strongly opposed to elimination of the nursing home quality standards we put in place back in 1987, with the leadership of our former colleague, Senator George Mitchell. These standards have just been fully put in force and were the result of recommendations made by the well-regarded Institute of Medicine in response to years of documented abuses in nursing homes. By turning back the clock to a time when we took our responsibility toward these most vulnerable citizens less seriously, we turn our backs on them.

Additionally, I have concerns about elimination of the spend-down and spousal impoverishment provisions which are so essential to many families who desire but lack the means to care for their infirm parents and grandparents.

Further, the proposed legislation makes significant changes in the

Medicaid drug rebate program which appear to essentially "gut" a program which has saved billions of dollars since 1991. I fail to see the reasoning behind watering down or eliminating this important program at a time when states need every possible means they can employ to save valuable health care dollars. We talk about eliminating strings so that states can save money -- here is a "string" that actually provides states with a lifeline that helps them stretch their dollars further.

Finally, Senator Chafee and I have had some discussions about the need to correct an unintended consequence of last year's GATT treaty which slows the ability of consumers and Federal health care programs to save money by purchasing generic drugs. Correction of this oversight would save hundreds of millions of dollars for Medicaid, and there would be additional savings to other Federal health care programs such as those run by the VA. I hope we will be able to address that problem as part of this legislation.

Mr. Chairman, as I mentioned earlier, we have a monumental task before us. I look forward to learning more about your proposal as the day proceeds.

SENATOR LARRY PRESSLER
OPENING STATEMENT
PROPOSALS FOR MEDICARE AND MEDICAID REFORM
SENATE COMMITTEE ON FINANCE
SEPTEMBER 26, 1995

Mr. Chairman, today we take the first step toward saving and strengthening Medicare. For years, we have been warned from both Republicans and Democrats that -- sooner or later -- something would have to be done about uncontrolled entitlement spending. Unfortunately, it came as a surprise to learn how soon a crisis would be upon us. In an April 3rd report, the Board of Trustees of the Federal Hospital Insurance Trust Fund stated that "the

trust fund does not meet the Trustees' short-range test of financial adequacy."

What does this mean? It means Medicare, the primary health insurance program for approximately 113,000 South Dakota seniors, will be officially bankrupt in seven years. This means that by November of 2002 there will be no money left in the Trust Fund to pay for the hospital and other health care services they currently receive under Medicare. Medicare, as we know it, would be gone.

Faced with this crisis, how has the Congressional Republican leadership

responded? We are responding by taking swift action. The Trustees -- three of them being members of President Clinton's cabinet -- state that "the Congress must take timely action to establish long-term financial stability for the program." That is exactly what the Senate Finance Committee's plan for Medicare reform would accomplish. How? Basically, our plan would take an inefficient out-of-date system from the 1960s, and make it work for the healthcare needs of the 1990s. This stronger, more efficient Medicare system would still grow but at a rate that will not result in a financial meltdown. Our plan would slow the growth of Medicare

from the current rate of 10.4 percent to a more reasonable 6.4 percent. That's still twice the rate of inflation, but a growth rate reasonable enough to enable Medicare to pass the Trustees' 10 year test for solvency. Each year, there would be more money to spend per South Dakota Medicare beneficiary -- specifically, $1918 per year over the next seven years.

This plan would more than just save the care elements of Medicare, it would make Medicare more user friendly for beneficiaries in different parts of the country. I thank Chairman Roth for his willingness to include in our plan a

number of reforms designed to improve Medicare for rural recipients. As a senator from a rural state lacking in managed care, I face the difficult task of defining the benefits of Medicare reform to a state comprised heavily of senior citizens, many of whom desire to remain in their current fee-for-service plan. South Dakota only recently began the move towards managed care. Many are uncertain as to how it can benefit rural areas. I believe the inclusion of this "rural package" in the Committee's Medicare reform plan would greatly enhance the quality of health care delivery systems in

South Dakota -- and all other rural states.

Mr. Chairman, it is time to play it straight with the American people. Medicare is too important an issue for partisan politics. There is still time to put rhetoric aside and work together in a bipartisan fashion to save Medicare from bankruptcy. My own mother is a Medicare beneficiary. Therefore, the issue of continued Medicare solvency hits very close to home for me. Simply seeking to destroy a reform plan is simply not an option. Leadership is needed. Medicare's trustees have said the time for

congressional action is now. If we do nothing, we can expect Medicare premiums to increase by 300 percent; payroll taxes will double, and Medicare will still go broke.

The bottom line for the Republican plan is simple: Our plan would preserve the Medicare system for future generations. Under our plan, Americans who are working and paying into the system would enjoy at least the same benefits and security that retired Americans enjoy today. We have responded to the message from the American people that Congress must save Medicare. South Dakotans have more than called for

action, they have provided me with a number of suggestions about how best we may preserve, protect, and improve Medicare. I am pleased, many of their concerns have been addressed, and met, in this reform package. Their voices are being heard. I have confidence that with this plan we will fulfill our goal. I want to thank my fellow South Dakotans for their guidance on this very complex subject. Their constructive contributions and suggestions will go far to make the Medicare program better and stronger. I am fortunate to be their Senator, and am also fortunate to play a part at a critical time in history, and

help deliver a comprehensive plan to ensure a better Medicare system for years to come.

With regard to Medicaid, I applaud the tremendous efforts of this Committee in developing a reform plan that will give states the opportunity to design and implement their own Medicaid plans in a cost-competitive environment. I believe this will go far in ensuring a more efficient system.

Currently, more than 65,000 South Dakotans are enrolled in the Medicaid program -- including 54 percent of the State's

nursing home patients. During 1994, South Dakota's Medicaid reimbursements totaled more than $263 million. These figures demonstrate how crucial Medicaid is in providing health care services to the people of my state. And South Dakota has been able to hold its rate of cost growth between four and five percent in recent years. I do have some concerns as to how a revised "federal match" formula will impact South Dakota, as the State has benefitted from a rather high -- but necessary -- federal matching rate. However, in an effort to address one of the most urgent problems facing our nation today -- our nearly $5 trillion debt -- we

in Congress <u>must</u> examine ways to slow the growth of Medicaid. And that is precisely what this Committee has done.