SPENDING REDUCTION PROPOSALS

HEARINGS

BEFORE THE

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UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

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SPENDING REDUCTION PROPOSALS

THURSDAY, MARCH 26, 1981

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10:08 a.m., in room 2221, Everett McKinley Dirksen Office Building, Hon. Robert J. Dole (chairman of the committee), presiding.

Present: Senators Dole, Packwood, Armstrong, Grassley, Moynihan, and Baucus.

The CHAIRMAN. We can go ahead and start. We have other members coming and going this morning, as we have in the past.

Our first witness this morning on the administration's spending reduction proposal is Gregory Ahart, Director of Human Resources Division, General Accounting Office, Washington, D.C.

As I say to other witnesses, you may proceed in any way you wish. Your entire statement will be made a part of the record. There probably will be some questions from members.

STATEMENT OF GREGORY AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C., ACCOMPANIED BY ANDREW KULANKO, AREA MANAGER, HUMAN RESOURCES DIVISION; LARRY ALDRICH, GAO EVALUATOR, LOS ANGELES REGIONAL OFFICE

Mr. AHART. Thank you, Mr. Chairman.

I have with me this morning Mr. Larry Aldrich from our Los Angeles Regional Office and Mr. Andrew Kulanko on my staff in the Human Resources Division.

I have a relatively short statement, but I will summarize it in the interest of time.

We have been asked to discuss principally today the minimum social security benefit reduction. We issued a report on this provision in December 1979, which recommended that the minimum benefit be repealed.

We have also reported on other provisions of the Social Security Act which, if modified or eliminated, could result in significant savings to the trust fund.

We would be happy to share with you our thoughts on these, if time permits, and if the committee desires.

I would like to explain briefly what our 1979 study encompassed, what the results showed, and why we believe the minimum benefit should be eliminated.

I should point out that the President's proposal to eliminate the minimum benefit differs from ours in that it applies to people on social security, as well as people who will become entitled to bene-

fits in the future. Our recommendation applied only to future beneficiaries.

We found that the minimum benefit provision, which was intended to help the poor, has in recent years mainly benefited retired government workers with pensions and homemakers supported by their spouses' incomes.

Ironically, most needy people receive no additional income from the minimum benefit because they are covered by the SSI program which requires a dollar-for-dollar offset for other income received.

Updated estimates show that eliminating the minimum for new beneficiaries would save $405 million during fiscal years 1982 through 1986, net of a $245 million increase in supplemental security income.

The Social Security Act has always had a provision for a minimum benefit. Its original purpose was to aid administration and to avoid paying benefits that would be of little value to the beneficiary.

Initially, the lowest monthly benefit possible was $10.

The Congress increased the minimum benefit over time because it believed most of the benificiaries were poor and needed assistance. In recent years, the Advisory Council on Social Security and others have pointed out that increasingly the minimum benefit is being paid to people who have not relied on their covered earnings as their primary source of income.

The Council labeled the minimum benefit a windfall when paid to these people. By its very nature, it does provide an unearned bonus or windfall. It establishes a minimum whenever the regular formula for computing benefits results in a smaller amount.

The phrase, "eliminate the minimum benefit," is somewhat misleading implying that minimum beneficiaries will no longer receive social security benefits. This is not the case. They would receive the payment resulting from applying the regular benefit formula to their work history of earnings.

In our study, we wanted to determine the income characteristics of the people who received the minimum benefit. We analyzed selected Federal records on a random sample of beneficiaries who were awarded minimum benefits during 1977.

We found three distinct minimum beneficiary groups. First, those who generally received no additional income from the minimum provision. That accounted for 44 percent of our sample. Those with other primary income, which accounted for 30 percent, and those for which there was insufficient data to determine the individual's financial status, the remaining 26 percent.

Included in the 44 percent, who receive no additional income were 18 percent who were supplemental security income recipients. As I have previously mentioned, there is a dollar-for-dollar offset required under this program.

Also, about 23 percent of our sample were dually entitled. That is, they were entitled to social security on either their own or their spouse's account, and the spouse's account provided the higher payment.

Of the 30 percent of our sample for which Federal records showed other primary sources of income, half received a Federal pension averaging $900 a month, and one-third depended primarily

on their working spouses, who were earning an average of at least $13,700 a year.

We were unable to determine from Federal records the extent to which the 26 percent depended on social security for their support. However, a more limited detailed analysis of a sample of beneficiaries in the Los Angeles area showed that most had some other primary means of support, such as State or local pensions.

Turning now to the characteristics of minimum beneficiaries, we found that most minimum beneficiaries were part-time or intermittent workers, never a permanent part of the labor force covered by social security.

Generally, they could not have depended primarily on the covered earnings because they were too low. Their average covered earnings were only about $22 a month for the period 1953 through 1976.

Only 3 percent had covered earnings of as much as $4,000 during any single year and only one-third had covered earnings of as much as $2,000 in any year.

Contrary to the concept of partially replacing covered earnings upon retirement, they received benefits that were about four times larger than their average monthly covered earnings.

Many persons had not worked in covered employment for several years before receiving social security. For these people, social security was a new source of income rather than a replacement for lost covered earnings.

Social security amendments in 1977 froze the entry level of minimum beneficiaries at $122 a month as of January 1979.

According to the Social Security Administration it would take more than 30 years for the freezing action to eliminate minimum benefits. Recognizing this and considering the financial condition of the social security trust funds, we recommended that the Congress repeal the minimum social security benefit provision for new beneficiaries.

That concludes my summary with respect to the minimum benefit provision, Mr. Chairman.

As I mentioned earlier, there are additional areas we have reported on where savings could be realized. Phasing out student benefits could save about $5 billion over a 5-year period.

Phasing out the death benefit could save about $2 billion during a 5-year period. Rounding benefit payments to the nearest penny, rather than the next highest dime, as is done now, would save about $390 million over the next 7 years.

Also, in a few weeks we will report that revising the benefit formula to stop the advantage it now provides to workers who worked for only short periods in covered employment could reduce expenditures by an estimated $11 to $15 billion over the next 10 years.

That concludes a summary of my statement, Mr. Chairman. We would be pleased to respond to any questions that you or other members of the committee might have.

The CHAIRMAN. I think with reference to that last statement, that report, you say, will be available soon?

Mr. AHART. That report will be available. I think we would be in a position to make a draft of it available most any time, Mr. Chairman.

The CHAIRMAN. It might be helpful because we are looking for some flexibility, I guess is the best way to put it, as we soon start trying to find some savings for this committee's jurisdiction. That might be very helpful.

Mr. AHART. Let us see if we can make a draft available to the committee for its use.

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Revising Social Security Benefit Formula Which Favors Short-Term Workers Could Save Billions

People who have worked for only a short period under social security receive proportionately more for their social security tax dollar than lifetime workers. In this report, GAO presents two alternative formulas for computing benefits which would end this favorable treatment. Adoption of either alternative could save the overburdened social security trust funds from $11 billion to $15 billion over the next decade, depending on the method used.

HRD-81-53
APRIL 14, 1981

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-202579

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses an idiosyncrasy of the social security benefit formula. It shows how people who have worked for only a short period under social security receive proportionately more for their social security tax dollar than lifetime workers. The report also identifies two alternative formulas for computing benefits that would end this advantage for the short-term worker and discusses the estimated savings that would result by implementing either alternative.

We recommend that the Congress consider these alternatives for ending this advantage to the short-term worker. The Social Security Administration has estimated that such action could save the social security trust funds as much as $15 billion over the next decade.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health and Human Services; and the Commissioner of Social Security.

Milton J. Socolar
Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

REVISING SOCIAL SECURITY BENEFIT FORMULA WHICH FAVORS SHORT-TERM WORKERS COULD SAVE BILLIONS

D I G E S T

The social security benefit formula ensures that low wage workers receive a proportionately higher return on their payroll tax contribution than workers with higher wages. This favorable rate of return is based on a "social adequacy" or welfare objective. The formula also provides this advantage to average or high wage earners who work for only short periods under social security (short-term worker advantage), although such an advantage may not be warranted for them. This advantage is created by spreading the worker's covered earnings over a lifetime (including many years with no or only noncovered employment) and applying the resulting artificially low average wage to a benefit formula that, for social adequacy purposes, is favorable for low wage earners. (See pp. 1 to 4.)

Short-term workers have contributed a relatively small amount of social security tax because they have had little work in covered employment. They receive, however, a higher return on their contribution than the average wage earner because of the benefit formula used to attain the program's social adequacy objective. In many instances, short-term workers have substantial income in addition to their social security. (See pp. 3, 4, and 9.)

Adverse economic conditions currently threaten the financial stability of the social security program. According to the Social Security Administration, stopping the short-term worker advantage could save as much as $15 billion over the next decade. Stopping the short-term worker advantage could also end "windfall" social security benefits to retired government (Federal, State, and local) workers who also receive a pension from their noncovered employment. (See pp. 7 and 15.)

Tear Sheet. Upon removal, the report cover date should be noted hereon.

MATTER FOR CONSIDERATION OF THE CONGRESS

Because a social adequacy benefit seems inappropriate for the average or high wage earner, and in view of the concern about the financial stability of the social security program, the Congress should consider revising the social security benefit formula to remove the advantage that it provides to the short-term worker. (See p. 19.)

GAO identified two methods of removing the short-term worker advantage:

--The continuation factor approach would allow full benefits only to people who have worked a lifetime in covered employment by adding a step to the benefit computation process which applies a factor based on the portion of a person's lifetime spent in covered employment to the computed benefit amount. (See pp. 10 to 12.)

--The bend point method would limit the amount of each year's earnings that may be applied against the highest rate of the benefit formula. (See pp. 12 to 15.)

AGENCY COMMENTS

The Department of Health and Human Services had no comment on GAO's report. (See app. I.)

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ABBREVIATIONS

AIME	average indexed monthly earnings
CPI	consumer price index
GAO	General Accounting Office
PIA	primary insurance amount
SSA	Social Security Administration

CHAPTER 1

INTRODUCTION

The social security benefit formula is weighted in favor of the low wage worker. Such workers get greater social security payments relative to payroll taxes paid than do average or high wage earners. Because this formula is applied to a "lifetime" average wage in employment covered by social security, the weighting not only helps the lifetime or long-term low wage worker, but also favors the high or average wage earner who had only short-term or sporadic work covered by social security taxes. The weighting advantage is based on a social adequacy or welfare objective which may not be warranted for short-term workers.

HOW BENEFITS ARE COMPUTED

A worker's social security benefit is determined by a multi-step process. First, the worker's covered earnings are updated (indexed) to reflect increases in the average wage of people working under covered employment. These indexed earnings, expressed as a monthly rate, are called average indexed monthly earnings (AIME). The worker's AIME is applied to the benefit formula to determine the individual's primary insurance amount (PIA). The PIA is the monthly amount payable to a worker retiring at age 65 or upon disability. It is also used to determine benefits for workers retiring before age 65 and for dependents and survivors of insured workers. For workers initially qualifying for benefits in 1979, the formula 1/ for computing the PIA is:

90 percent of the first $180 of AIME, plus
32 percent of the next $905 of AIME, plus
15 percent of the AIME above $1,085.

The PIA computed under this formula, however, cannot be less than the minimum PIA of $122, or the special minimum benefit calculated by multiplying $11.50 by the number of years of covered employment 2/ in excess of 10 (and up to 30).

1/This formula was established by the Social Security Amendments of 1977. It is adjusted automatically as average wages increase. For example, the formula for a person becoming eligible in 1980 is: 90 percent of the first $194 of AIME, plus 32 percent of the next $977, plus 15 percent of the AIME above $1,171. Transitional provisions of the 1977 amendments allow workers attaining age 62 in 1979-83 to elect benefits based on the formula existing before the amendments.

2/A year of covered employment for this provision generally requires earnings in that year equal to or greater than one-fourth of the social security tax base.

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THE BENEFIT FORMULA IS WEIGHTED FOR SOCIAL ADEQUACY

The social security benefit formula is a compromise between the objectives of individual equity and social adequacy. Individual equity is a reasonable relationship between taxes paid and benefits received. Social adequacy is a welfare objective which attempts to assure everyone of a basic income level. The benefit formula provides individual equity by relating benefits to the earnings on which taxes are paid. This relationship is modified to achieve social adequacy goals by weighting the formula in favor of workers with low average earnings and by a minimum benefit provision.

LOW WAGE WORKERS RECEIVE SIGNIFICANT ADVANTAGE

The weighting of the social security benefit formula and the minimum benefit significantly favor the low wage worker. For example, compare the return of benefits on payroll taxes paid for the average wage earner with that of a low wage earner and that of a beneficiary with the $122 minimum benefit.

Comparison of Return on Taxes Paid

Description	Average wage earner	Low wage earner	Minimum beneficiary
AIME (note a)	$ b/817	$ 248	$ 100
Lifetime social security taxes paid (note c)	5,186	1,578	635
January 1, 1979, PIA	366	184	122
Social security benefits for 1979 (note d)	3,716	1,867	1,239
Portion of taxes returned by 1979 benefits (percent)	72	118	195

a/Earnings indexed to 1977.

b/AIME of a career average earner, age 62 in 1979.

c/This is an estimated tax based on a method discussed on page 6. Actual tax can vary significantly.

d/Based on the January 1979 PIA reduced for retirement at age 62 and increased by the 9.9-percent cost-of-living adjustment effective for the June 1979 benefit.

The effect of the weighted benefit formula and the minimum benefit is evident when comparing the return of the three beneficiaries--the lower the covered earnings, the greater the return on taxes paid.

SHORT-TERM WORKERS ALSO RECEIVE A HIGHER RETURN

The social security computation method allows people who worked intermittently under covered employment the same favorable return on payroll taxes as those who worked under social security throughout their lives at low wages.

For example, assume that three workers retire at age 62 in 1979: a short-term worker who earned average wages while working and two career workers--a low wage earner and an average wage earner. The short-term worker has covered earnings in 7 of the 28 possible years since 1950 (one-fourth of that time) at indexed monthly earnings of $817 during the covered earnings period. The low wage earner has covered earnings in 23 years since 1950 (or the full computation period 1/) at indexed monthly earnings of $248. The average wage earner has the same indexed monthly earnings as the short-term worker ($817), but worked at that wage throughout the period used to compute social security benefits. The following table shows the return on taxes paid for the three workers under the social security computation method.

1/The computation period for social security benefits is generally defined as the number of years between 1950 (or the year the worker turns 21, if later) and the year that the worker attains age 62, becomes disabled, or dies, excluding the 5 years of lowest covered earnings.

Return on Taxes Paid by Short-Term and Career Workers

	Short-term worker	Career workers	
	Average wages	Low wages	Average wages
Monthly indexed earnings:			
While working	$ 817	$ 248	$ 817
Used in formula (AIME) (note a)	248	248	817
PIA (note b)	184	184	366
Taxes paid (note c)	1,578	1,578	5,186
1979 benefits	1,867	1,867	3,716
1979 benefit per tax dollar	1.18	1.18	.72

a/The AIME is based on the total indexed earnings of the highest 23 years since 1950 divided by 276 months (12 x 23).

b/For illustrative purposes in this report, we do not show the effect on PIA of the transitional provisions of the 1977 amendments.

c/This is an estimated tax based on a method discussed on page 6. The actual tax can vary significantly.

The short-term worker with average wages received the same favorable return as the career low wage earner--$1.18 for every dollar in taxes paid. Although the short-term worker's earnings while working were the same as the average wage earner, his or her return was greater ($1.18 for each tax dollar versus $0.72).

The short-term worker advantage may account for as much as two-thirds of a person's benefit. In the above-mentioned example, it is 39 percent--$0.46 ($1.18-$0.72) of each $1.18 of benefits. This advantage is created by spreading the worker's covered earnings over a lifetime 1/ (including many years with no or only noncovered employment) and applying the resulting artificially low average wage to a benefit formula that, for social adequacy purposes, is favorable for low wage earners.

1/A lifetime is considered as the computation period used in the social security benefit formula. See the footnote on the previous page for the general definition of the computation period.

OBJECTIVE, SCOPE, AND METHODOLOGY

During our recent review of minimum social security benefits, 1/ we became aware of the advantage that short-term workers receive from the benefit formula. We believed that this advantage was equal to or greater than the advantage of minimum social security benefits and that stopping this advantage could help the financially troubled social security trust funds. Therefore, we initiated this review of the short-term worker advantage to determine its significance and identify alternative benefit formulas.

Our minimum benefit study and the Advisory Council on Social Security's December 7, 1979, report indicated that individuals who work under social security for short periods often have substantial retirement income other than social security, and that those without additional income may be better served through such means-tested programs as Supplemental Security Income. We did not seek new information on the needs of short-term workers because we believed that the primary issue was that people should not derive an advantage from the benefit formula solely because they had not worked much of their life under social security. Therefore, we sought to identify alternatives to the present benefit computation method and the savings that could result.

We reviewed the legislative history of the benefit formula and studies by various groups, such as the Advisory Council on Social Security and held discussions with Social Security Administration (SSA) officials. Based on this research, we identified two methods of stopping the short-term worker advantage, both of which preserved social adequacy objectives for low wage workers under social security for all or most of their working life. Although there could be many alternatives for stopping the short-term worker advantage, the alternatives we chose will not require significant modification to the benefit formula and will not alter the basic structure of benefits to workers with many years of employment under social security.

We discussed the two alternatives with social security actuaries and asked them whether they had the data base on which to estimate the potential saving to the social security trust funds if either method was implemented. They responded that the data base that they used to estimate the impact of the 1977 amendments to the Social Security Act could be used for this purpose and later gave us the requested estimates. We did not verify the validity of these estimates because of the extensive effort that would be required.

1/"Minimum Social Security Benefits: A Windfall That Should Be Eliminated" (HRD-80-29, Dec. 10, 1979).

In this report, we use the "return on social security taxes" as an indicator of the relative equity between lifetime and short-term workers. While it is useful as such, it should not be used as an indicator of the value of a participant's taxes relative to the value of benefits received. This "return" does not consider the time value of money, future benefit increases, life expectancy of beneficiaries, the insurance value of social security coverage, and many other factors.

The method we use to illustrate the inequity of the short-term worker advantage has pitfalls as any method illustrating this inequity will. This is because we are dealing with an issue that has many variables because it involves both the benefit formula and a person's work history. First, there is not just one social security benefit formula, but rather a basic formula with several alternative formulas. Second, the characteristics of individual work histories are numerous and varied, including some who work in covered employment during only their early working career and others who join the system at an older age, while others have erratic earnings over their lifetime. Finally, the formula that is required in a specific case may not include all of a person's work history.

While we believe that our illustrations are useful in discussing the short-term worker advantage, the method we use to compute a person's "return on social security taxes" is not designed for the analysis of specific individuals. For example, to compute a person's "lifetime" social security taxes we used an estimated tax rate derived from the indexed earnings and social security taxes paid each year by a worker reaching age 62 in 1979 who had earnings equal to the maximum tax base for 1951-78. Then, we applied this single rate to the indexed earnings in only those years that were included in the computation of benefits. The actual lifetime tax for an individual might be quite different than what we would compute with this method because many people have covered earnings in years that are not included in the computation of benefits, and the actual tax rate has not been constant, but has increased over the years.

Our work was done principally at SSA headquarters in Baltimore, Maryland.

CHAPTER 2

CAN SOCIAL SECURITY AFFORD THE SHORT-TERM WORKER ADVANTAGE?

The Advisory Council on Social Security and the Congress have expressed concern over the short-term worker advantage, asking such questions as: (1) do beneficiaries with a few years of covered employment often have other primary means of support and (2) can the trust fund afford to favor beneficiaries who have done little to earn social security? In 1949 the House passed legislation that proposed using a "continuation factor" to remove the short-term worker advantage. The Senate rejected this proposal. However, today circumstances are different, particularly in regard to the solvency of the social security program.

SOCIAL SECURITY FUND FACES AN IMPENDING SHORTAGE

The Board of Trustees for the Federal Old-Age and Survivors Insurance and Disability Insurance trust funds projects that the old-age and survivors fund will be exhausted in late 1981 or early 1982. In its 1980 report, the Board recommended that the shortage be addressed in part by adopting legislation which would allow any of the three social security trust funds 1/ to borrow from each other. While the Board's report projected adequate combined trust fund balances through the end of the 1980s, it warned that revised short range estimates would probably be necessary because of recent adverse economic changes.

Recent SSA estimates show a precariously low combined trust fund balance by the end of 1984. According to these estimates, the balance of the combined funds will be 7.5 percent of anticipated 1985 expenditures. This is less than 1 month's outgo. If this occurred, SSA could not make full payments in January 1985.

The assumptions on which these estimates are based appear optimistic, and if so, the combined funds could run short before 1985. The assumptions include consumer price index (CPI) increases in 1981 and 1982 of 9.7 and 8.9 percent, respectively--low compared to the 1980 increase of 14.3 percent. This tends to show lower benefit increases than would be expected with higher CPI increases. On the other hand, average covered wage increases of 9.7 and 9.8 percent are assumed for the same period. These rates are higher than ever experienced before and tend to show higher revenues than might be expected.

1/Old-Age and Survivors Insurance, Disability Insurance, and Health Insurance trust funds.

The financial stability of the trust funds is more than a short range problem. The Board's 1980 report indicated that interfund borrowing would assure long range (through 2054) solvency of the combined funds only under optimistic assumptions. These assumptions include annual, long range CPI increases of only 3 percent and long range unemployment rates of only 4 percent.

CONCERN OVER THE ADVANTAGE FOR SHORT-TERM WORKERS

The Advisory Council on Social Security expressed concern about the short-term workers' advantage in the social security benefit formula. In its December 1979 report, it stated:

> "* * * people who spend only a relatively small portion of their working lives under social security will generally have been supported at least in part by other sources of income during their lives. Because most such workers will not have relied solely on their own covered earnings during their potential working lives, a benefit that replaces those lost earnings can similarly not be expected to be their sole support in retirement. Attempting to provide a poverty-level benefit to people with a history of less than full-time attachment to the labor force would seriously erode the wage relatedness of benefits and would significantly increase program costs. The job of assuring a minimally adequate income to those part-time workers who are in need is more properly the role of means-tested programs, such as supplemental security income."

Our minimum benefits study 1/ supports the Advisory Council's belief that many people who spend only a relatively small portion of their working lives under social security generally have been supported by other income. Our report showed that most minimum beneficiaries awarded benefits in 1977 had little work in covered employment. Most of those beneficiaries were supported by other income. For example, about 15 percent were retired Federal civil servants supported by Federal pensions and 35 percent were homemakers depending primarily on either their spouse's income or their spouses's social security benefits.

The short-term worker advantage has been labeled a "windfall" when paid to retired government (Federal, State, and local) employees who also receive a pension from their noncovered employment. This is because many government retirees receive a social

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1/"Minimum Social Security Benefits: A Windfall That Should Be Eliminated" (HRD-80-29, Dec. 10, 1979).

security benefit that is weighted in favor of the low wage workers and their low covered earnings are not representative of their true earnings considering covered and noncovered employment. Such an advantage to retired government employees with substantial pensions is particularly inappropriate because the weighting is based on the social adequacy or welfare objective of the social security program. Stopping the short-term worker advantage would eliminate this "windfall" to retired government employees.

Stopping the short-term worker advantage would not affect the "windfall" to retired government employees who had part-time work in employment covered by social security throughout their government career. However, there is no consensus as to what this "windfall" is or even as to whether such a part-time worker receives a "windfall."

In the past, the Congress has been concerned about benefit advantages to short-term workers. In 1939, the House Ways and Means Committee reasoned that an advantage or bonus to workers with few years of covered employment was justified in the early years of the social security program because people had had insufficient time to earn substantial benefit rights. However, the Committee believed that in the long run such bonuses were unwise and endangered the solvency of the system. The formula established in 1939 was designed to increase the adequacy of the system during its early years as well as relate benefits to length of covered employment.

In 1949, the House passed legislation to modify the social security benefit formula. The proposed computation method was similar to the 1939 method except that it used a "continuation factor" to establish a reasonable differentiation between the benefits of short-term and lifetime workers.

The Senate Finance Committee rejected the continuation factor as well as the feature of the formula that related benefits to length of covered employment--a 1-percent increment in the benefit amount for each year of covered employment. The Committee believed that basing benefits on lifetime average earnings provided "sufficient differentiation" between the short-term and lifetime worker. Short-term workers' benefits were smaller because periods without covered employment lowered their average earnings.

Circumstances which may have a bearing on the question of sufficient differentiation are different now than when the continuation factor was rejected. At that time, there was no federally guaranteed minimum income level for aged, blind, and disabled, such as provided by today's Supplemental Security Income program. Also, the Congress had not expressed a concern about social security "windfall" to retired government workers. Perhaps more important, the social security program was not in danger of insolvency.

CHAPTER 3

STOPPING THE SHORT-TERM WORKER

ADVANTAGE COULD SAVE BILLIONS

Restructuring the social security benefit formula to remove the advantage provided to people with few years of covered employment could save social security trust funds as much as $15 billion over the next decade.

We identified two methods of removing the short-term worker advantage. One is the "continuation factor" adjusted for use with the current social security benefit formula. An SSA actuary suggested the other method called the "bend point" method.

CONTINUATION FACTOR

The continuation factor removes the short-term worker advantage by allowing full benefits only to people who have worked a lifetime 1/ in covered employment. It does this by adding a step to the benefit computation process, which applies a factor--based on the portion of a person's lifetime spent in covered employment--to the computed benefit amount. For example, persons who worked throughout their lifetime in covered employment would receive all of their computed benefit and those who worked only half of their lifetime would receive 50 percent of their computed benefit.

The following example illustrates how the continuation factor would be applied to a short-term worker whose indexed earnings were $817 a month during the period that he worked. Assume that a worker retires at age 62 in 1979 with indexed wages of $68,628 earned during 7 (84 months) of the 23 years used in computing benefits. Under the 1979 formula, this worker's PIA is $184. Using the continuation factor, the worker's PIA would be $111, computed as follows:

1/A lifetime is considered as the computation period used in the social security benefit formula. See the footnote on page 3 for the general definition of the computation period.

Step 1 Average indexed earnings in years worked:

$$\frac{\$68,628}{84 \text{ months}} = \$817$$

Step 2 Application of the 1979 benefit formula to average earnings:

90 percent of $180	=	$162
32 percent of 637	=	204
$817		$366

Step 3 Continuation factor for portion of period worked:

$$\frac{28 \text{ quarters (note a) (7 years)}}{92 \text{ quarters (23 years)}} = .304$$

Step 4 PIA: $366 x .304 = b/$111

a/See the footnote on page 16 for the definition of quarters of coverage used in the continuation factor.

b/For illustration, we are showing the computed PIA. Under law, however, a worker's PIA cannot be lower than the $122 minimum benefit. Also, transitional provisions discussed in 1/ on page 1 have not been applied.

The continuation factor is designed to equalize the return on social security taxes for workers who have had equal earnings during the period that they have worked. To illustrate, compare the return under the 1979 formula to that with the continuation factor for (1) the above short-term worker, who had indexed earnings of $817 a month while working and (2) a lifetime worker with the same monthly wage.

Illustration of Continuation Factor
Equalizing Return on Taxes Paid

	Under 1979 formula		With continuation factor
	Short-term worker	Lifetime worker	Short-term worker
Monthly indexed earnings	$ 817	$ 817	$ 817
Lifetime social security taxes:	1,578	5,186	1,578
PIA:	184	366	a/111
Monthly benefits (note b)	147	293	89
Total 1979 benefits (note c)	1,867	3,716	1,131
Yearly benefit for taxes paid	1.18	.72	.72

a/For illustration, we are showing the computed PIA. Under current law, however, a worker's PIA cannot be lower than the $122 minimum benefit.

b/Reduced for early retirement.

c/Benefits for January through December 1979 adjusted for the June 1979 benefit increase.

With the present formula, this short-term worker received $1.18 in 1979 social security benefits for each $1 of lifetime social security tax. The person who worked a lifetime at the same wage received 46 cents less. The continuation factor eliminates this inequity and provides the same rate of return to each.

BEND POINT METHOD

The bend point method removes the short-term worker advantage by limiting the amount of each year's earnings that may be applied against the highest rate (90 percent) of the benefit formula to 12 times the first "bend point" of that formula. The first bend point is the AIME above which the benefit formula rate changes from 90 to 32 percent. (See p. 1.) The bend point is $180 for a person retiring at age 62 in 1979. Under this method, the 1979 PIA for the person who had indexed monthly earnings of $817 for each of 7 years would be computed as follows:

Step 1	Lifetime indexed earnings 7 years at $817 a month 16 years at $0 earnings	$68,628
Step 2	Limit for maximum rate 7 years at $180 a month (7 x 12 x $180)	$15,120
Step 3	Computation period (23 years)	276 months
Step 4	AIME ($68,628 divided by 276)	$ 248
Step 5	Amount of AIME at maximum rate ($15,120 divided by 276)	$ 54
Step 6	Amount of AIME at lower rate ($248 minus $54)	$ 194
Step 7	PIA: 90 percent of $ 54 = $ 49 32 percent of $194 = 62 $111	a/$111

a/Without considering the $122 minimum benefit.

The bend point method gives the same PIA as the continuation factor except when a worker's monthly indexed earnings fluctuate above and below the bend point. For example, assume that the worker used to illustrate the continuation factor on page 11 had monthly indexed earnings of $147 for 2 years and $1,085 for 5 years. The bend point PIA is computed as follows:

Step 1	Lifetime indexed earnings		
	2 years at $ 147 a month	$ 3,528	
	5 years at $1,085 a month	$65,100	$68,628
Step 2	Limit for maximum rate		
	2 years at $147 a month	$ 3,528	
	5 years at $180 a month	10,800	
		$14,328	$14,328
Step 3	Computation period (23 years)		276 months
Step 4	AIME ($68,628 divided by 276)		$ 248
Step 5	Amount of AIME at maximum rate ($14,328 divided by 276)		$ 51
Step 6	Amount at lower rate ($248 minus $51)		$ 197
Step 7	PIA: 90 percent of $ 51 =	$ 46	
	32 percent of $197 =	63	
		$109	a/$109

a/Without considering the $122 minimum benefit.

Using the continuation factor, this person's PIA would be $111. The bend point method gives a smaller PIA of $109 because the monthly indexed earnings of each year subject to the 90-percent rate is limited to $180 a month; whereas under the continuation factor, the 90-percent rate is applied to the first $180 of the average indexed monthly earnings during the period worked which allows earnings from years when the monthly indexed earnings were above the $180 bend point to compensate for years when they were below. When a worker's earnings fluctuate like this, the bend point method produces a smaller PIA. Otherwise, the two methods result in about the same benefit.

Some may argue that the continuation factor or bend point method unfairly discriminates against women, because many of them were not working during their childbearing and childrearing years. The continuation factor or bend point method, however, does not unfairly discriminate against women. Either of these changes eliminates an inequity in the social security formula that pays higher benefits to anyone, female or male, who has worked sporadically. The SSA estimates on page 16 indicate that nearly half

of the benefit reduction would apply to male workers or their families.

One possible explanation for why women may be less affected than some might expect is that many retired women who were occasionally employed during their childbearing years are "dual beneficiaries." That is, they are entitled to social security benefits on either their own account or their husband's account, whichever is higher. In such cases, it is less likely that a woman's benefit would be affected by either of the revised computation methods if the benefit from her husband's account was higher than that from her account.

ESTIMATED SAVINGS

SSA estimates (see next page) show potential trust fund savings for the next decade varying from $11.4 billion to $15.6 billion, depending on which method is used. Since the short-term worker advantage cannot be totally removed without eliminating the effect of the $122 minimum benefit provision, the estimates show the potential savings both when the minimum benefit is retained and when it is eliminated in conjunction with the introduction of the new method of computing benefits.

This SSA estimate is based on the assumption that the new method would have applied to workers who attained age 62, became disabled, or died after 1980. Because of inflation, later implementation of the new formula would result in greater savings during the first 10 years. This savings, of course, would continue beyond the 10-year period; and most likely, at an increasing amount. While the total savings are significant, SSA believes that stopping the short-term worker advantage alone would not prevent depletion of the social security trust funds.

Estimated Impact of Restructuring Benefit Formula

Fiscal year (note a)	Trust fund savings: With continuation factor — With minimum	With continuation factor — No minimum	With bend point — With minimum	With bend point — No minimum
	(millions)			
1	$ 41	$ 47	$ 48	$ 55
2	146	166	171	194
3	291	328	341	382
4	490	567	574	661
5	768	911	896	1,057
6	1,094	1,312	1,270	1,515
7	1,481	1,780	1,706	2,043
8	1,905	2,294	2,181	2,622
9	2,358	2,833	2,690	3,233
10	2,839	3,397	3,233	3,874
10-year savings	$11,413	$13,635	$13,110	$15,636
Beneficiary data				
Portion of beneficiaries awarded lower benefits (percent)	24	29	28	33
Portion of benefit reduction from:				
Female workers	52	54	53	55
Male workers	48	46	47	45

a/This savings will vary depending on how quarters of coverage are defined. For this estimate, quarters of coverage were derived from the indexed earnings in the years used to compute benefits (computation years) with a quarter deemed to be equal to the earnings required for a quarter of coverage in the indexing year.

NEAR MAXIMUM SAVINGS WITHOUT ELIMINATING THE MINIMUM BENEFIT

The greater savings under both methods (see table above) include both (1) eliminating the $122 minimum benefit and (2) removing the short-term worker advantage. Savings near this amount are possible without eliminating the minimum benefit if the continuation factor is required only when the beneficiary has less than full coverage--fewer quarter years of covered employment than

there are in the worker's benefit computation period. When the continuation factor is required, the factored benefit would prevail over the minimum provision; if the factor is not required, the minimum would apply. Using this method, the minimum benefit provision would not be eliminated. It just would not apply to the short-term worker.

Requiring a person to have full coverage before receiving full benefits is not as severe as it may seem. First of all, the 5 lowest years of earnings are not included in the benefit computation. Thus, a worker can have 5 years with no covered employment and not have his or her benefits reduced. Also, a person can earn 1 year of coverage in 1 or 2 months of covered employment (since under the 1977 Social Security Amendments, coverage is based on yearly earnings--in 1978, $1,000 in covered wages earned a year of coverage). Finally, when computing benefits any covered employment after age 62 replaces periods without employment before age 62.

SUBSTANTIAL SAVINGS POSSIBLE WITH LIMITED APPLICATION

To reflect the traditional compromise between social adequacy and individual equity objectives the continuation factor's "full coverage before full benefit" requirement could be modified and still achieve substantial savings. The following schedule shows SSA's estimate of the savings possible by requiring the continuation factor at different covered employment levels.

Savings With Limited Continuation Factor (note a)

Fiscal year	Level of employment required to avoid continuation factor (more than) 3/4	2/3	1/2	1/3
	(millions)			
1	$ 36	$ 31	$ 17	$ 5
2	129	109	59	17
3	254	215	121	34
4	440	374	228	80
5	712	613	385	154
6	1,031	894	569	248
7	1,405	1,218	784	354
8	1,824	1,581	1,027	470
9	2,262	1,963	1,277	600
10	2,714	2,351	1,528	736
10-year total	$10,807	$9,349	$5,995	$2,698

a/Data presented under the assumption that if the continuation factor is required the minimum benefit provision does not apply.

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The schedule shows, for example, $10.8 billion savings during the decade if the factor were applied only to people who had covered employment in no more than three-fourths of the computation years.

Limited implementation of the continuation factor has a disadvantage in that it introduces some significant differences between the benefits of people who have just enough quarters to avoid application of the continuation factor and those who fall just a little short. Such a sharp distinction between these people may not be desirable. Also, some of the savings shown on page 17 may not be achieved because of the relatively modest effort required of some people to attain the additional coverage necessary to avoid application of the continuation factor.

CHAPTER 4

CONCLUSION AND MATTER FOR CONSIDERATION OF THE CONGRESS

CONCLUSION

The social security benefit formula favors not only people who have had low earnings over a lifetime of continual employment, but also those whose average earnings are low because of many years without covered employment. While the importance of providing greater replacement of preretirement earnings to those who worked at low wages for a lifetime is well recognized, one could question whether intermittent workers should get a similar advantage. They have not relied on their earnings covered by social security before retirement and often have other primary means of support after retirement. Such an advantage for those with other income may be an unnecessary drain on the social security trust funds. Needy short-term workers could be cared for through a means-tested program, such as Supplemental Security Income.

We identified two methods of removing the short-term worker advantage. SSA estimates that removing the short-term worker advantage could save up to $15 billion during the next decade depending on which method is used and how it is implemented. SSA believes, however, that these savings alone would not prevent depletion of the social security trust funds.

MATTER FOR CONSIDERATION OF THE CONGRESS

Because a social adequacy benefit seems inappropriate for the average or high wage earner and in view of the concern about the financial stability of the social security program, the Congress should consider revising the social security benefit formula to remove the advantage that it provides to the short-term worker.

AGENCY COMMENTS

The Department of Health and Human Services, after reviewing a draft of this report, said in a March 2, 1981, letter to us, that it had no comment. (See app. I.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request of January 30, for our comments on your draft report entitled, "Social Security Benefit Formula Favors Workers Who Paid Social Security Taxes Only a Short Period--Revising the Formula Could Save Billions." We have carefully reviewed your report and have no comments at this time.

Program officials did note some technical questions relating to definitions of terms and computation methodology; however, these problems have been resolved informally with your office and appropriate clarification will be reflected in the final report.

Thank you for the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Acting Inspector General

Enclosure

(105086)

The CHAIRMAN. Now, you indicate that your proposal is somewhat different from the President's. The President's is about a billion dollars, and yours, you say, was 400——

Mr. AHART. I think the difference, of course, is that the President's proposal would apply the elimination of the minimum benefit to those people now on the rolls, as well as to those coming on the roll.

The CHAIRMAN [continuing]. Right.

Mr. AHART. That makes a difference when you net out against the supplemental security income program. I think the President's figure was about $5.2 billion, as against our net figure of $400-some million over that 5-year period. So, it is quite a difference.

The CHAIRMAN. Do you have any information—did your survey uncover any information on the age distribution of minimum benefit recipients?

There has been some concern that a great many of these recipients are quite elderly and are drawing the minimum benefit for a number of years.

Mr. AHART. This was not included in our study, Mr. Chairman, because we were looking only at people that had just come on the rolls in 1977, and our recommendation only went to eliminating the benefit for new beneficiaries.

Now, obviously, if you eliminated the benefit for people already on the rolls, you would, obviously, get some of those beneficiaries who are quite elderly and probably need that income.

I don't know what that breakdown would be by age. We have not studied it. I suspect that the Social Security Administration could provide that kind of information.

The CHAIRMAN. Could you explain to me, maybe I missed the point on the 44 percent of the sample generally receive no additional income.

Will you spell that out for me?

Mr. AHART. Well, the two largest parts of that fraction, Mr. Chairman, are, first, 18 percent who are eligible for, and are receiving supplemental security income. What happens in that program is that they have a supplemental security income entitlement of, say, $300. Anything that they receive from other sources, including minimum benefits under social security of, say, $122, is offset against that. So, if they are eligible for SSI and are receiving the minimum benefit, they would receive the full amount of $300, but they would receive $122 of that from the trust funds and the remaining $178 from the SSI program. If the minimum benefit were eliminated, they would get some lesser amount from the trust funds and a greater amount from general revenues, but their net take would be the same.

Now, the other part of that fraction, the main part, I should mention——

The CHAIRMAN. That would be 26.

Mr. AHART [continuing]. Well, the 23 percent, included within the 44 percent is made up of people that are dually eligible. These are generally people whose spouse is eligible and they are entitled under their spouse's social security account to so much.

They are also in their own right entitled to a minimum benefit. What happens in that situation is that under the social security

accounting method they get a benefit which is higher than the minimum, but the $122, or whatever the minimum benefit portion is, is shown as being drawn on their account. The remainder is being drawn on their spouse's account.

But, if you eliminated the minimum benefit, they would get less on their own account, more on their spouse's account, but still get the same check every month.

The CHAIRMAN. There is some reference to Los Angeles here, let's see, you indicate that you couldn't determine from the Federal records the extent to which the 26 percent depended on minimum social security benefits for their support.

As I understand the finding in Los Angeles indicated that most of those people had some other primary means of support?

Mr. AHART. Yes. What we did there, Mr. Chairman, was that in our main study and our main sample, we looked only at Federal records, the information that is already available in the Federal record system. In Los Angeles, we decided to supplement that by going out with questionnaires to beneficiaries and getting information from them as to what their financial situation was. And by that device we were able to narrow that fraction for which we didn't have sufficient information down from 26 percent in our main sample to 15 percent in our Los Angeles sample and learn more about it.

We considered going with a questionnaire on a nationwide basis, but that was a little bit too expensive for our purposes. However, from the Los Angeles experience we do know that a substantial part of that 26 percent are people who do have other sources of income, but which cannot be identified in the Federal record system.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. I have no questions, Mr. Chairman.

The CHAIRMAN. Senator Armstrong had a couple of questions, but he may have gotten called away.

Let me see if I can ask the questions that Senator Armstrong had in mind.

Probably one that has been raised—raised earlier a couple weeks ago, and we discussed this—was elimination of this minimum benefit would be administratively expensive.

Do you have any cost estimates on what it would cost to eliminate the provision and implement the proposal?

Mr. AHART. I would have to break that down two ways. Again, I think you have to talk separately about what the President has proposed and what we have recommended.

As far as our recommendation is concerned, since it applies only to new beneficiaries, it should not result in any additional administrative expenses because you still have to make the computation for people coming on the rolls.

Now, the President's proposal would require a recomputation for all those people now receiving minimum benefits that are already on the rolls. I think that could get rather expensive administratively.

If I understand that proposal correctly, what would be required would be that for each one of those people that are now receiving minimum benefits, Social Security would have to go back and

recompute what they would have been entitled to under the regular formula and then bring that up to date with the cost of living increases that have been made since they went on the rolls to come up with a new benefit amount.

That would be a rather major administrative undertaking and I would guess quite expensive. Again, not for the ones coming on the rolls, but rather for those on the existing rolls.

The CHAIRMAN. Senator Moynihan, do you have any questions?

Senator MOYNIHAN. No, thank you, Mr. Chairman.

The CHAIRMAN. Senator Armstrong was called away and if he has additional questions, I might—would it be all right if he submits those in writing and you can respond to the record?

Mr. AHART. Certainly, Mr. Chairman.

The CHAIRMAN. Thank you very much. I appreciate it.

[The prepared statement of Hon. Gregory J. Ahart follows:]

STATEMENT OF GREGORY J. AHART, DIRECTOR OF HUMAN RESOURCES DIVISION

We are pleased to be here today to discuss the Minimum Social Security Benefit. As you know, we issued a report in December 1979 recommending that the Congress eliminate the minimum for new beneficiaries.

In addition to that report, we have also identified and reported on other provisions of the Social Security Act which if modified or eliminated could result in significant savings to the social security trust funds. I will mention these later in my testimony and we would be happy to share with you our thoughts on each of these if time permits and the Committee is so inclined.

You have asked, however, that today we focus our attention on the minimum benefit provision. I would like to now explain briefly what our 1979 study encompassed, what the results showed, and why we believe the minimum benefit should be eliminated.

At the outset, I should point out that the President's proposal to eliminate the minimum benefit differs from our recommendation in that it applies both to people on social security as well as people who will become entitled to benefits in the future, while our recommendation applied only to future beneficiaries. Also, our study was directed at beneficiaries just coming onto the rolls—not those already on the rolls for an extended period of time.

We found that the minimum benefit provision, which was intended to help the poor, has in recent years mainly benefited retired government workers with pensions, and homemakers supported by their spouses' incomes. Ironically, most needy people receive no additional income from the minimum provision because they are already covered by the Supplemental Security Income program, which requires a dollar for dollar offset for other income received.

Since our report, the Social Security Administration has provided updated estimates showing that eliminating the minimum for new beneficiaries would save the Government $405 million during fiscal years 1982-1986. This figure is the net of a $650 million savings in social security and a $245 million increase in Supplemental Security Income.

THE MINIMUM BENEFIT PROVISION

Before discussing our study, I would like to comment on the purpose and nature of the minimum benefit. The Social Security Act has always had a provision for a minimum benefit. Its original purpose was to aid administration and to avoid paying benefits that would be of little value to the beneficiary. Initially, the lowest monthly benefit possible was $10.

Over a period of several years, the rate of increase for minimum benefits was more than twice that for other social security benefits. The Congress increased the minimum benefit because it believed most of the beneficiaries were poor and needed assistance.

In recent years, however, the Advisory Council on Social Security and others have pointed out that, increasingly, the minimum benefit is being paid to people who have not relied on their covered earnings as their primary source of income. Such people include government workers who received substantial income from their government pensions. Also included are homemakers whose spouses have substan-

tial income. The Advisory Council on Social Security labeled the minimum benefit a "windfall" when paid to these people.

The minimum benefit, by its very nature, provides an unearned bonus or windfall to people who have had very low lifetime earnings covered by social security. It establishes a minimum for all eligible beneficiaries that is used whenever the regular formula for computing benefits results in a smaller amount. For example, if the worker's benefit as computed by the formula was only $40, he or she would receive the higher minimum benefit of $122. The difference of $82 is an unearned bonus created when the Congress raised the level of the minimum benefit to assist people who had little or no other income.

The phrase "eliminate the minimum benefit" is somewhat misleading, implying that minimum beneficiaries will no longer receive social security benefits. Of course, this is not the case. When the minimum provision is repealed, these people will receive the payment resulting from applying the regular benefit formula to their work history. They would no longer receive a bonus if the application of this formula resulted in a lower amount.

INCOME CHARACTERISTICS OF MINIMUM BENEFICIARIES

In our study, we wanted to determine the income characteristics of the people who receive the minimum benefit. We analyzed selected Federal records on a random sample of beneficiaries who were awarded minimum benefits during 1977. The selected Federal records analyzed included, for example, payment data on the Supplemental Security Income program and Federal pensions. They did not include IRS data.

The results of this analysis showed three distinct minimum beneficiary groups:

(1) Those who generally receive no additional income from the minimum provision—44 percent of the sample were in this group.

(2) Those with other primary income—30 percent were in this group.

(3) Those for which there was insufficient Federal data to determine the individual's financial status—26 percent.

As I said, about 44 percent of our sampled beneficiaries received no additional income from the minimum provision, primarily because of offsets required in other Federal benefits. For example, 18 percent of sampled beneficiaries were Supplemental Security Income recipients. Generally those who receive the social security minimum benefit and also qualify as Supplemental Security Income recipients do not receive any increase in their overall monthly income from the minimum benefit provision because of the dollar for dollar income offset required under the Supplemental Security Income program. Also, about 23 percent of our sampled minimum beneficiaries were "dually entitled." That is, they were entitled to social security on either their own or their spouse's account, and their spouse's account provided a higher payment. Under the law, the dually entitled person is paid the higher of the two entitlements. Consequently, the minimum benefit provision does not increase the benefits of the dually entitled person.

Of the 30 percent of our sample for which Federal records showed other primary sources of income, half (or 15 percent of the sampled beneficiaries) received a Federal pension averaging $900 a month, and one-third (or 10 percent of the sample) depended primarily on their working spouses who were earning an average of at least $13,700 a year.

We were unable to determine from the Federal records the extent to which the 26 percent of the sample depended on the minimum social security benefit for their support. However, a more detailed analysis of a sample of beneficiaries in the Los Angeles area showed that most of these people had some other primary means of support, such as state or local pensions.

WORK CHARACTERISTICS OF MINIMUM BENEFICIARIES

Much discussion has been focused on the minimum beneficiaries retirement income needs. But also important to the question of whether to retain minimum benefits, are the minimum beneficiaries' work characteristics. We found that most minimum beneficiaries were part-time or intermittent workers—never a permanent part of the labor force covered by social security.

Sampled minimum beneficiaries generally could not have depended primarily on their earnings from covered employment because they were too low. Their average covered earnings were only about $22 a month for the period 1953-76. Only 3 percent of the minimum beneficiaries had covered earnings of as much as $4,000 during any single year in that time period, and only one-third had covered earnings of as much as $2,000 in any one of those years.

Contrary to social security's concept of partially replacing a person's covered earnings upon retirement, sampled beneficiaries received benefits that were about four times larger than their average monthly covered earnings before receiving social security.

Many persons had not worked in covered employment for several years before receiving social security. Nearly half had not worked in covered employment for 5 years, and about one-third for 10 years. For these people, social security was a new source of income upon becoming eligibile for the minimum benefit, rather than a replacement of lost covered earnings.

The Social Security Amendments of 1977 froze the entry level of minimum beneficiaries at $122 as of January 1979, but allowed cost-of-living increases for these beneficiaries after they become eligible for social security. Under these amendments, anyone becoming eligible for the minimum benefit would initially start drawing benefits based on the minimum primary insurance amount of $122, but would thereafter receive benefit increases based on the Consumer Price Index, as under the prior law.

According to the Social Security Administration, it will take more than 30 years for the freezing action to eliminate minimum benefits.

Recognizing this and considering the financial condition of the social security trust funds, we recommended that the Congress repeal the minimum social security benefit provision for new beneficiaries.

That concludes my comments on the minimum benefit provision. As I mentioned at the beginning of my statement, however, there are additional areas we have identified and reported on where additional savings in the social security program could be realized. These include the phasing out of both post-secondary student benefits and the lump sum death benefit and rounding benefit amounts to the nearest penny or nearest dime. Phasing out student benefits could save about $5 billion over a 5-year period. The Congressional Budget Office estimates that phasing out the death benefit could save about $2 billion during the 1982-1986 period. In 1978, we estimated that rounding social security benefit payments to the nearest penny rather than to the next highest dime would save about $386 million over the next 7 years. Our reports on these and other matters were summarized in our December 1980 report to the Congress "Implementing GAO's Recommendations on the Social Security Administration's Programs Could Save Billions (HRD-81-37).

Also, we expect to issue a report to the Congress in a few weeks which will discuss the need to revise the social security benefit formula to stop the advantage it provides to short-term workers who work for only short periods in employment covered by social security. Such a revision could reduce social security expenditures by an estimated $11 billion to $15 billion over the next 10 years depending on the method used and whether the minimum benefit is eliminated.

That concludes my statement Mr. Chairman, we would be happy to respond to the Committee's questions.

The CHAIRMAN. Our next witness is Robert M. Ball, a former Commissioner of Social Security, 1962 to 1973.

Mr. Ball, we are happy to have you before the committee again, and you have had a lot of experience.

You may proceed any way you wish.

STATEMENT OF ROBERT M. BALL, FORMER COMMISSIONER OF SOCIAL SECURITY, 1962-73, WASHINGTON, D.C.

Mr. BALL. Thank you, Mr. Chairman.

I have a rather long statement that I would like to have included in the record with your permission.

The CHAIRMAN. Yes. It will be made a part of the record.

Mr. BALL. And, Mr. Chairman, I would also like to submit a two-page memorandum supplementary to that statement which is related to a long-range cost estimating problem. This memorandum was developed by Dr. Chen, who is the research director of the McCahan Foundation for Research in Economic Security. I think it is a major contribution to this subject.

The CHAIRMAN. Do we have that too?

Mr. BALL. I have not distributed it. I just have the one copy.

The CHAIRMAN. Oh, I see, fine.

We'd like to have a copy of that. That will be made a part of the record.

Mr. BALL. Thank you, sir.

[The information follows:]

SOCIAL SECURITY COST AS REPRESENTED BY THE PERCENTAGE OF TAXABLE PAYROLL

(By Yung-Ping Chen)[1]

The cost of social security in a given year is generally expressed as a percentage of the taxable payroll in that year. This study analyzes the relationship between the cost of social security and the representation of that cost as a percentage of taxable payroll. A given level of social security expenditures will be represented by a higher percentage of taxable payroll if the taxable payroll declines as when the cash form of pay becomes a smaller part of total employee compensation. With the assumption of a continuous decline in wages and salaries as part of total compensation, the OASDI cost in the year 2035 is estimated to be 17.17 percent of taxable payroll. If the ratio of cash pay to total pay does not decline as assumed, the cost will be represented by a smaller percentage of taxable payroll. What follows is a summary of the analysis.

Based upon the latest official intermediate-cost estimates for the 75-year projection period 1980–2055, OASDI cost as a percentage of taxable payroll is estimated to decline from 1980 to 2000, to rise from 2000–2035, and then to decline from 2035–2055. There would be a 65-percent increase in cost from 2000–2035, reaching 17.17 percent of taxable payroll in 2035, the highest in the 75-year period.

Because these higher percentages imply very much higher social security tax rates, it is important to recognize a very significant factor pertaining to the taxable payroll itself.

For all practical purposes, the taxable payroll can be thought of as analogous to the cash component of employee compensation and self-employment earnings subject to social security taxes. Over the years, wages and salaries as a percentage of total employee compensation have continually declined: 84.2 percent in 1980, compared to 90 percent in 1970 and almost 96 percent in 1940 when social security first began monthly benefit payments. During the last four decades, supplements to wages and salaries (generally known as fringe benefits, though not all fringe benefits) have grown substantially in both absolute and relative terms.

Significant but little-known about the projected percentages of taxable payroll is the assumption of a continuous decline in the ratio of cash to total employee compensation. The assumed decline is at the annual compound rate of .4 percent from 1980 to 2055: from 84.2 percent in 1980 to 62.2 percent in 2055. According to this trend, as supplements to wages and salaries grow, the taxable payroll shrinks relatively because cash pay becomes a smaller part of total compensation. Consequently, a given level of benefit payments will mean a higher percentage of taxable payroll.

For example, suppose today out of $1,000 of employee compensation, $840 is cash pay and hence is taxable payroll, and suppose $84 is required for paying social security benefits. Taxing $84 out of $840 means a 10-percent tax on taxable payroll. Now suppose in a future year, for every $1,000 of employee compensation only $620 will be in cash form and therefor is taxable payroll, and suppose the same amount of social security benefit payment, $84, will be required. Taxing $84 out of $620 of cash pay means a tax rate of more than 13.5 percent of taxable payroll.

Of course, the assumed trend toward increasing proportions of supplements (or fringes) may or may not materialize. Because of the practice of expressing social security cost in terms of taxable payroll, it is important to recognize that the relative shrinkage of the cash versus noncash forms of compensation will raise the percentage of taxable payroll required, even when the cost of social security stays the same over time. For this reason, one must be careful about comparing the percentages of taxable payroll required for OASDI costs over time.

Mr. BALL. Mr. Chairman, I've summarized, as the committee requested, the major points that I'd like to make concerning the President's proposals for the budget. The summary is on page 2 of my statement and I would like to comment briefly on each of the items. Hopefully, I can get through my original statement in 10

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[1] Speaking for himself, Yung-Ping Chen is research director, McCahan Foundation for Research in Economic Security, professor of economics of the American College, Bryn Mawr, and consultant to the 1981 White House Conference on Aging.

minutes or less, so we can have time for whatever questions the committee has.

The first point that I would like to stress is that although social security has turned out to be our most effective antipoverty program, and that it keeps about 14 or 15 million people above the poverty line who otherwise would be below it, that is not all it is. Social security today is the base upon which all private savings for these risks of retirement in old age, for total disability and for death of a family breadwinner is built.

Every private pension in the country assumes that its pensioners will be receiving social security. All savers assume that they have a base of social security. This means to me that the most important characteristic of the social security system is dependability. It must be a system people can count on.

I distinguish sharply the social security contributory wage-related program from other programs supported by the general revenues of the Federal Government. Over the years, we have built brick-by-brick a social insurance system in which people have a compact with the government. They pay in earmarked social security taxes in return for defined protection.

Now, I'm not one that says that that compact can never be changed. Of course, the Congress can make changes, but I would urge that they be made with care over a long period of time. It is quite inappropriate as part of an annual budget process to make long-range changes in the protection that people have been paying toward and counting on in this program.

I feel it was a great mistake when the change was made after fiscal year 1969 to include the social security system in the unified budget. The two major committees of the Congress concerned with social security have never proposed changes in the social security system except changes that they felt were related to the internal logic of the system and they were careful to recommend, to the best of the ability of the estimators, full financing for the program.

Up until now, social security has not been considered a proper subject for getting quick savings in a unified budget, and I hope it won't be now. This is quite aside from the merits of any particular proposal.

I would argue that with the benefit rights, based on past contributions and earnings, with the promises stretching into the distant future that the annual budget process is not the way to handle this program.

Second, Mr. Chairman, the unprecedented proposal to reduce benefits for people already on the rolls seems to me a kind of action that can undermine the sense of dependability that pension plan managers need, that individuals need, and that the country needs to have about a contributory social insurance program like this.

If I could just take the example of the minimum benefit, which Mr. Ahart was commenting on. It so happens that I have never been enthusiastic about the regular minimum benefit. I have consistently argued against increasing the minimum benefit throughout the years, but it seems to me that to take people already receiving it and recomputing their benefits is the wrong way to go about modifying any benefit. If I'm right, as I think I am, that the

most important characteristic of the program is dependability, such a proceedure is very harmful to social security.

It also seems to me that the action which the Congress took in 1977 of gradually phasing out the minimum benefit was just right. It may take 30 years to get completely rid of it that way, but it has major effects quickly. And as you remember, the action of the Congress was to freeze the minimum at $122 and since all other benefits and the insured status requirements are related to wages and brought up to date as average wages increase, the $122 minimum just phases out and without making people feel that they have had promised benefits taken away from them.

I think that is an excellent example of how direction should be changed in this long-range social security system, just what you did in 1977.

Senator, did you want me to proceed?

The CHAIRMAN. Go ahead.

Mr. BALL. It is not enough, in my view, to merely not change the benefits for people already receiving them. To stick with the minimum benefit: a person now 60 or 61 who expects the payment, I think, also has a serious grievance against the program if the benefit is suddenly taken away.

Phasing out or modifying the general direction of a provision seems to me, completely appropriate.

I will skip, Mr. Chairman, in the interest of time, to just a touch on the financing of the program. Underlying many of these recommendations has been the idea not solely of savings in the short term unified budget, but a kind of pervasive feeling that we need to cut back on social security somehow because of the difficulties in financing it.

I would like to separate out, just for quick comment, three periods of financing social security.

The CHAIRMAN. Did you, by chance, see the proposal that Congressman Pickle—he didn't introduce it yesterday but at least he's chairman of the Social Security Subcommittee of Ways and Means.

I think there was some story in the paper this morning about some suggestion had been made. Have you had a chance to look at that?

Mr. BALL. Yes, Mr. Chairman, though Mr. Pickle was very careful to indicate it was not his proposal——

The CHAIRMAN. Right.

Mr. BALL [continuing]. Or the committee's proposal. It was just for discussion and there are possibly many modifications that will be made in it. I am aware of the general provisions.

The CHAIRMAN. I didn't want to interfere, but I think you presented it properly. It is not his proposal, but one of the better ones that he has seen in the past years.

Mr. BALL. I like many things in that proposal and disagree profoundly with many others, as I am sure you would expect.

One thing they've come up with, I think, is very interesting and that is their suggestion that the States and localities pay the Federal Government more promptly by having the money flow to the Federal Treasury with the same speed that is required of other employers.

That doesn't sound like much. It actually turns out to save the social security system something over $1 billion in fiscal year 1982 because of the speedup in collections, with additional interest earnings for social security in later years. That doesn't hurt anybody's benefit.

Mr. Chairman, just very briefly, on the general financing situation, there is a very short-term problem in the Old Age and Survivors Insurance Fund, which you are fully aware of and I'm not going to take time on it, except to distinguish it from what might be called the middle-range problem.

This very short-range problem can be dealt with, if you wish, by relatively minor measures such as interfund borrowing and a reallocation of rates if you are willing to accept quite optimistic economic assumptions, particularly if accompanied by moving the scheduled 1985 increase up to 1984.

My own view on the very short-term problem is that it would probably be better to take somewhat more pessimistic economic assumptions and do a more fundamental type of restructuring the financing as in Mr. Pickle's draft bill. He suggests that one-half of Medicare be financed from general revenue and that you move over to the cash program the social security contribution rate that you free-up from that change.

I think we need to build back a major contingency fund in social security. We need to make sure that if the projections turn out to be wrong in two or three years that social security is not back on the front pages. I believe we should have a conservative financing plan.

So, as I say, it would be possible under optimistic economic assumptions to get by with relatively minor changes for short term financing.

Now, middle-range financing, say the next 25 years—I think the situation here is very much misunderstood. Under the official estimates of the trustees, cash social security benefits actually decline as a percentage of payroll during this period. There is not a continuing increase in cost arising from an older and older population during the next 25 years.

The aging-of-the-population problem for social security, insofar as it exists, is a next century problem. It occurs, if at all, when the baby boom generation reaches retirement age, say from about 2005 to 2030.

Although we do have an increase in the number over 65 in the next 25 years, this increase is balanced by an increase in the people paying in. During this period, the baby-boom generation is of working-age. So, the demography question is really the long-range question in my statement. I have many comments on the assumptions used in making the long range cost estimates.

In summary, I'd say, it seems to me a mistake to cut back on long term protection in social security on the theory that we know what is going to happen some 50 to 75 years from now and to take action, such as increasing the first age of eligibility for full benefits, as if we did. I go into that question in some detail.

So, to conclude, Mr. Chairman, I have not commented individually on the President's proposals because they are fairly technical and it would take time. I think it is clear to you already, but let me

make it very explicit: I oppose each one of the cuts on the merits, as well as opposing the use of the budget process to set social security policy. I would hope that the most objectionable feature, which is to cut benefits for people on the rolls—not just the minimum, but student benefits, too—would be changed by this committee at the very least. This committee and the Ways and Means Committee have acted like a board of directors for the social security system over the years and have given social security policy continuity. I hope you will reject these sudden, unprecedented policy changes.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Ball.

In case Pat has to leave early, I am going to be here in any event, I'll yield to Senator Moynihan.

Senator MOYNIHAN. Oh, no, Mr. Chairman, I am going to be here.

Mr. Chairman, I think it would be best if the Republicans be allowed to plan the budget.

The CHAIRMAN. Senator Packwood had to leave temporarily and he said if he didn't return, he wanted to have this question asked.

As I understand it, the administration has recommended repeal of the medicare payment for pneumococcal vaccine. Do you have any policy observations you can share with the committee regarding this recommedation?

Mr. BALL. I like the way you passed it last year and I see no reason to withdraw on that, Mr. Chairman.

The efficacy of the pneumococcal vaccine is well established. The Office of Technology Assessment went into this very thoroughly, as well as outside groups. This is not an expensive benefit. I believe, however, that it was a real breakthrough to add a preventive type of benefit to the medicare program.

Up until now, Medicare has been almost entirely payment for curative services. I think it is great to start thinking about at least a limited number of services that are of proven preventative value, as a way of, in the long run, saving money, as well as, of course, promoting health.

So, to repeal the provision that would encourage people to get the pneumococcal vaccine, which is very important because it is a disease that affects older people in very large numbers, would seem to me a mistake.

The CHAIRMAN. As I recall, we had quite a struggle over that amendment. We finally, in the last hours of Congress, as I recall, attached enough savings to pay for the amendment and that was accepted by the House with some reluctance. So, we thought we had it paid for.

Well, in any event, I appreciate that comment.

Now, as I understand, you wouldn't at this time do anything to social security based on the reasons set forth including not enough notice to those who may be affected. Do you have any comments—and you may have made recommendations in your statement—on cost-of-living adjustments?

This has been an area where the President says he will not tread. In fact, he has told members of both parties that he does not

want to tamper with that area. Do you think that's an area that should be addressed in the future by the Congress?

Mr. BALL. Senator, if a technical review of the cost-of-living provision on an objective basis by the experts that work in this area—and I'm not one of them—demonstrated that the cost-of-living measure now used, the CPI, was not the best measure of a true increase in the cost-of-living, I think, of course, it should be changed.

I would be opposed, however, to arbitrary changes which are designed in such a way that the people who get social security benefits and the other people whose benefits are tied to the cost-of-living do not have their benefits kept up-to-date as prices rise. Retired people are very vulnerable to inflation with no bargaining power to make up for the situation later.

So, it seems to me very, very important to protect the concept of the cost-of-living. I would not, certainly, hold—I'm not capable of judging; I'm not expert enough—to hold that the exact way the CPI is now constructed is correct.

Many economists have been saying things like the mortgage interest rate part of the CPI has created a situation in which people have been over-compensated in the past. But, of course, it's true that it you were to change it, and mortgage interest rates started to go down—since you are just measuring the difference—you would be taking the action just at a time when you might have saved money from doing nothing. Also there is considerable lag and the benefits are not fully kept up to date with the CPI.

So, I think there are complications.

The CHAIRMAN. So, as I understand, you would not touch the student benefits either. In any event, you would make it prospective and not impact on anyone currently receiving these benefits.

Mr. BALL. Mr. Chairman, my own view is that the benefits payable to the sons and daughters of deceased people, retired and disabled people who are attending school is a perfectly legitimate part of this social insurance system. That to many, many workers it is important to leave when they die, for example, money that can help their children as long as they are in school, so that I dislike the idea of getting rid of this part of social security. But it is certainly true that I dislike some part of the proposal more than others, and the idea of affecting people who are either already getting it, or just about to get it seems to me particularly damaging to people's faith in the program to which they have been contributing.

It undermines faith in the dependability of the benefits.

The CHAIRMAN. But as I understand, that benefit is based on the earnings record; it doesn't have much to do with the educational needs——

Mr. BALL. Right.

The CHAIRMAN [continuing]. Or the cost of education, or the financial status of the student.

Mr. BALL. Absolutely. You are absolutely correct, Mr. Chairman, and I think that is the way it should be. Consistent with the concepts of social insurance, this benefit is a partial substitute for parental support. It is trying to put this motherless or fatherless

child in a position similar to those who still have parents to depend on.

The other programs, such as the Basic Opportunity Grant program is supplementary to either parental support or to the social security benefit for those people who are truly in need. Social security does not have, and shouldn't in my opinion, the idea of directing the benefit just to people who can meet an income or an asset test.

I'm particularly disturbed, Mr. Chairman, by the fact that in the budget recommendations, it is argued, in effect, that there is a better way to meet the purpose of the students benefits, while at the same time there isn't additional money allowed for people who would turn to Basic Educational Opportunity Grants if the social security benefit were cut, or to turn to the loan program—as a matter of fact, as you know, it is now suggested that the loan program should have an income test. So, on principles, I dislike to change in general. I particularly dislike applying it to people already getting a benefit, or, those about to get it, say, a widow with a 16-year-old son or daughter who has been counting on this help for the child when he or she goes to a technical school or wants to finish high school and go on to college.

I had thought this was a settled issue. I remember the President in the debate with President Carter made a strong point that any proposals that would come out of the task force that he said he was going to set up would not pull the rug out from under people who were already receiving benefits.

So, I find proposals or the minimum and the student benefits something of a surprise and in disagreement with the position which he took in that debate.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman.

One of the things I would like to ask our distinguished witness are just twofold. It seems to me in discussing, for example, the student benefit we are always—you know, you have the motherless, the fatherless child, and so forth. What proportion of the people receiving this benefit are, in fact, children of a mother who has died and continued to be supported by a perfectly well employed father; it is fairly high is it not?

Mr. BALL. I don't have the figures, Senator, but I would suspect that it was the smaller proportion, and relatively small.

The children of retirees are also eligible, and that would be quite small. On the other hand, the children of the disabled might be a fairly sizable number.

Senator MOYNIHAN. Yes.

Mr. BALL. I think the reason people tend to use the motherless or fatherless child is that taken together they make up the bulk of this beneficiary category.

Senator MOYNIHAN. I guess I have just the simple view that we have never yet found an increase in this program that wasn't warranted, necessary, and untouchable. We now have, I guess, for every person receiving retirement benefits, there are three people in the work force; is that not right?

Mr. BALL. Well, three covered workers under social security, yes.

Senator MOYNIHAN. In the year 2000, there will be two. It is getting to be—we thought we had taken care of this for the next 25 years in 1977, and it seems we took care of it for about four. I wanted to ask this: the thing that I am surprised, Mr. Chairman, I even note today the most striking the proposals the President has sent us have to do with children in the AFDC program where has been cutting and cutting and cutting.

We don't even have anybody here to talk about children, save, Mr. Smith who will speak to some of the medically—children who need medical treatment of special kind.

Mr. Ball, I wonder if you have some comment on—the children are left out of this; they are not indexed; they are not fully supported by the Federal Government and when we talk about their program, we talk about it in terms of behavior of adults.

The Washington Post, as you know, has proposed that the AFDC program be abolished so people could stop bitching about it. It becomes such a symbol of things. If you listened to Presidents and Secretaries, and so forth, it's not just this one, at least, you would think that the population of the AFDC program consisted entirely of adult males.

What do you think—I've observed in the President's budget that it is the children who are going to find themselves most reduced. The retired people aren't going to be touched at all, and how did we get into this situation? Why did we—first, you are a repository of national memory here, how come the AFDC was made a State sharing program and the retirement system was not?

Mr. BALL. Senator, I don't—just before I directly answer your question—I don't think it is quite right to say that retired people aren't touched by the President's proposals.

In the minimum benefit proposal he would reduce benefits for 2 million people now receiving those benefits. But leaving that aside, I certainly agree with the general position from which you are asking your question: the reductions in the AFDC program seem to me extremely bad. This program, which, of course, is a means tested program operated by the States—they, by and large, determine the level of payment with the Federal Government putting up more than half the money—goes to the poorest of the poor. It is very, very largely for women who have small children. It should be one of the last places, it would seem to me, to be cut.

Now, I don't want to put it in competition with the social insurance program. The reason that the retirement benefits under social insurance are treated quite differently, I believe, is because as you know so well, social insurance has quite a different purpose and is structured very differently. Social insurance is contributory, is based on past earnings, and is not, by any means, just for low-income people, but is the base on which everybody builds protection. Every pension plan in the United States is built on the idea that their pensioners can also expect a social security benefit.

So, you have a different kind of support for social security. The AFDC program doesn't have a broad constituency; it isn't based to the same degree on a sense of right, and I deplore that.

Senator MOYNIHAN. May I just make—my time is up and I don't want to keep you, Mr. Chairman, but I just want to make one point.

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After the last election when there was—it didn't seem that it was necessary to spend too much time planning the new Democratic legislative program, we set to work doing some, well, scholarship, if you might say, and we worked out a set of projections starting on these matters that go back from a series that we developed from 1940, 1950, 1960, 1970 and, Mr. Chairman, you would be particularly sensitive, I think.

We can establish at a very high order or probability now, that means it is on the curve, that as of today a cohort of children born in 1980, 52 percent will live in a single parent female-headed family before they are 18. And of the children born in 1980, 32 percent—we round it to a third because we're not that hard—one-third will be supported by the AFDC program.

It is next to the public school, clearly the most important public program for children the country has and the President's proposals reduce it—I'm not saying they are all wrong at all, but I mean, you know, it is fundamentally important that no one comes up here to speak about the subject.

If we don't do it, no one will, and particularly the groups who might most be expected to be here aren't.

But that is a striking figure, a third of the children. And that is the one that's not indexed, and in the new proposals would take all the work incentives out. It would make a difference between a mother working and a mother not working practically zero in net income, which seems not to be the way our committee has tried to work in the last 15 years or so.

I thank you very much.

The CHAIRMAN. Thank you.

Mr. BALL. Senator, Mr. Chairman, could I comment on one other point that Senator Moynihan made as he was giving preparatory remarks to a question? I don't want to leave the record with the implication that I agreed with his statement that we now have three workers contributing to one person retired and we would later have two contributing for one. It is correct that we have approximately three to one now, and it is projected by the official cost estimates that sometime about 2025 it will turn out to be two to one. But I want to throw some doubt on that. That depends upon a whole series of assumptions about the payers-in. It assumes, for example, that we will continue to have a smaller proportion of older people employed than we do today. That instead of reversing that trend after the baby boom retires when there well may be more opportunities for older people to work.

It assumes that immigration will not grow any faster than the present legal limit. One response to a labor shortage situation in the early part of the next century might be increased immigration.

It assumes that fertility rates will not rise above the replacement rate. I think these assumptions can be defended, but I think they can also be challenged. It is not a certain thing. The long-range actuarial deficit in the official cost estimates for social security depends largely on what happens from 50 to 75 years from now.

Now, another very important point is that in addition to the number paying in and the number paying out, the high cost that the social security actuaries get 50 to 75 years from now is based in part on the assumption that total compensation for workers will be

less and less made up of wages and salaries in the future and more and more in fringe benefits. Wages and salaries, of course, are all that are subject to social security taxes so this assumption increases the estimate of the needed rate of social security taxes.

Now, to some extent, I think it is justified, to assume some increase in the proportion of compensation represented by fringe benefits. But their present projection just takes the past trend of four-tenths of 1 percent a year, projects it indefinitely for 75 years in the future without ever coming to a leveling off place. It does not seem to me reasonable to think that workman's compensation, unemployment insurance, social security, private pensions are all indefinitely going to keep increasing at the expense of wages and salaries paid currently. So, I think that is something worth looking into, too.

Senator MOYNIHAN. That is a fair point, thank you.

The CHAIRMAN. Do you have any other questions, Senator Moynihan?

Senator MOYNIHAN. No. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Ball.

We will probably be asking you for additional advice when we get into the nitty-gritty of this.

Mr. BALL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. BALL. It is a pleasure to be here again. I have spent many days in this room.

[Statement follows:]

STATEMENT OF ROBERT M. BALL, U.S. SENATE, COMMITTEE ON FINANCE

Mr. Chairman and Members of the Committee: My name is Robert Ball. From April 1962 until March 1973, I was Commissioner of Social Security and prior to that served for approximately 20 years in various positions in the Social Security Administration and its predecessor organization, the Social Security Board. Since leaving the government, I have continued my deep interest in social security and have written and lectured extensively on the subject. I was a member of the most recent statutory Advisory Council on Social Security, which reported to the Executive and the Congress in 1979.

I am testifying today, however, as an individual, and my opinions do not necessarily represent those of the Advisory Council or any other organization with which I am or have been associated.

I appear today to oppose the social security recommendations in the budget. I want to make six points:

(1) Because social security is a self-financed social insurance system, with rights growing out of past earnings and contributions and with benefit promises coming due many years in the future, the annual budget is not the appropriate mechanism for considering program modifications.

(2) It will undermine people's faith in social security to take the unprecedented action of reducing the social security benefits of those already receiving them.

(3) The individual proposals for modification of the social security system are, in my opinion, undesirable.

(4) If any of these modifications are to be made, ample notice should be given so that people who now have reason to count on the promised protection are not adversely affected.

(5) To strengthen public confidence in the system, rather than chipping away at benefit protection, there should be an increased allocation of social security taxes to the cash benefit program.

(6) It is not necessary or desirable to cut benefit protection because of a fear that social security costs in the next century will be increasingly difficult to bear.

(1) The nature of social security makes the budget process an inappropriate vehicle for considering program changes.—The purpose of the annual budget is to make choices among expenditures, giving preference in the budget period to one expenditure over another, and also to determine who pays what and how much for the

expenditures. Social security promises—stretching into the distant future, resting on past earnings and contributions, and with separate financing—are not a proper part of this essentially competitive process. The obligations of social security result from an agreement to furnish certain protection in return for certain payments by workers and employers and the self-employed. The agreement can, of course, be changed. But the changes need to be made with great care, with respect for accrued rights, and for reasons that relate to the internal logic of the program. Otherwise, popular support, which rests on the dependability of program promises, cannot be maintained.

Thus, it seems to me that social security policy decisions need to flow, as they have in the past, from the careful consideration of program modifications by this Committee and the Committee on Ways and Means in the House of Representatives and not be dictated by overall budget policy in a particular year.

Perhaps it is worthwhile to summarize, for the record, some of the characteristics of social security that distinguish it sharply from most other programs of government. The details of the social security law are so complicated, and the rules and regulations so numerous, that sometimes one forgets that the basic idea is very simple. All there is to it is that, while people work and are earning, they pay social security taxes on their earnings, with their taxes matched by the employer, and with the self-employed, too, paying in while they work. When earnings stop or are greatly reduced because of retirement or because one is too disabled to work, or because a family has suffered an income loss when a wage earner dies, then benefits are paid by the system to partly make up for these lost earnings. The cash benefit part of social security is "income insurance"—protection against the loss of income, just as other insurance protects against the loss of a house through fire or the loss of an automobile in case of an accident. It is a social insurance program, similar in many respects to a huge group insurance and retirement program. It is based on a compact between the contributing worker and the government, which promises to pay benefits under defined conditions in return for earmarked social security taxes.

The program affects just about every American family. Today it provides monthly benefits to 35,000,000 people—one out of every seven Americans. Another 115 million Americans are building protection through payments into the program. Social security is self-financed by the contributions of these covered workers and their employers and the self-employed.

There is not only a legal right to the defined benefits—a denied claimant can go to a Federal court for redress in the event of improper denial—but the right to protection is an earned right, earned by the work and contributions of those who benefit from the system. The payments reflect the beneficiaries' previous levels of living and thus serve in some measure as a reward for diligence, and the benefits are payable without the scrutiny of individual means and needs and so permit supplementation by the recipients' savings. Because they are payable as an earned right, the benefits accord with the self-respect of people accustomed to providing for themselves.

Social security is built on the conservative principle of self-help, with the protection growing out of past work, but it has, nevertheless, created a revolution, transforming life for millions of people from poverty and in security to relative economic well-being.

In 1935, when the Social Security Act was passed, less than 15 percent of the jobs in the United States were covered by any sort of retirement, disability, or survivors' insurance system, and only a tiny proportion of those over 65 were drawing retirement benefits. Many people ended their lives in a now almost forgotten institution, the "county poorhouse." This year 95 percent of the people reaching age 65 will be eligible for social security payments, and most of those who are not will be eligible for retirement pay from some other government system, such as railroad retirement, Federal civil service, or a state or local plan. Social security and other government retirement plans are now providing just about universal protection. This is a remarkable achievement of just the last generation, and it has been built carefully, block by block.

Everyone knows how important social security is for the elderly, but it is also of great importance to earners who are middle-aged and younger, not only because they are building protection for themselves when they retire—no one stays young—but because they have protection currently against the risk of becoming totally disabled and because their families have protection against the loss of income due to their deaths. Increasingly, too, middle-aged and younger workers understand the importance of social security as a better way of supporting the older generation than the direct support that they would otherwise have to provide to their own parents and relatives.

Recent polls show much appreciation of the importance of social security protection, but at the same time they show concern about its dependability. Given the importance of social security to just about everyone, I believe we must do everthing we can to strengthen public confidence in the dependability of social security promises. This requires considering program modifications from the standpoint of long-range desirability of the change rather than from the standpoint of the current status of the unified budget.

Although social security is our most important anti-poverty program—keeping some 13 to 14 million persons above the poverty line—it is much more than that. Today, social security is the base on which just about everyone builds protection against income loss. In one way or another, all private pension systems, for example, count on the fact that the pensioner will also receive social security benefits, and the individual saving on his own for supplemental protection counts on social security as the base. The most important characteristic of this basic system of social security must be dependability. How else can individuals and private pension managers plan how to supplement the program?

(2) Reducing Benefits for Those Now Receiving Them Is Unprecedented and Will Undermine Confidence in the System.—The worst feature of the social security budget recommendations is that they provide for cutting the benefits of those who have met all the requirements in present law, have submitted proof that they meet the requirements, have received and award letter signed by the Commissioner of Social Security certifying their entitlement to benefits of a certain amount, and are actually receiving such benefits. It is now proposed that the law be changed and that the benefits already awarded to some three million persons receiving the minimum benefit and 800,000 persons receiving the benefit payable to young survivors and dependents attending school be cut substantially.

Quite aside from the merits of modifying or not modifying the program to eliminate particular benefits in the future, I believe it would greatly undermine faith in the general dependability of social security to lower benefits for those already receiving them. If such cuts can be made for minimum beneficiaries, for example, who is safe?

I had thought this was a well agreed upon point. For instance, in the debate with President Carter on October 24, 1980, President Reagan said, in proposing a new task force on social security, ". . . with the premise that no one presently dependent on social security is going to have the rug pulled out from under them and not get their check." Later in the same debate he said that beneficiaries ". . . must continue to get those checks."

(3) I Disagree with the Individual Proposals on the Merits.—(a) The elimination of the minimum benefit. I am not one of those who believe that no deliberalizing changes can ever be made in social security, but I do believe that such changes should be made gradually, with respect for accured rights, and with due notice.

I do not favor the retention of the regular minimum benefit for social security over the long run. I believe such a minimum provides too large a benefit return for workers with relatively slight attachment to social security coverage, and I have consistently opposed increases in the minimum benefit for many years.

However, it seems to me that the gradual phase-out of the minimum benefit, as provided for by the 1977 amendments, was exactly right; it is unfair to change the rules in the middle of the game and tell people who have been counting on these benefits that they will get much less than they have been told they would.

Under present law, as a result of the 1977 amendments, the initial value of the primary insurance amount is frozen at $122; in the future, an age 65 retiree will receive no more than $122 unless his or her preretirement earnings justify a higher benefit. Over the years—since all other benefits are updated to current earnings—it will become increasingly unlikely that workers with sufficient earnings to be insured will be eligible at age 65 for a benefit of as little as $122. Thus, over time, the regular minimum benefit will gradually phase out. This seems to me a very good example of how a modification in social security policy can be made without risking the loss of public confidence that comes from recomputing benefits for those now receiving them, or changing the rules for those who are counting on getting certain benefits in the future.

(b) Elimination of benefits for young survivors and dependents attending school. Since the social security amendments of 1965, the life insurance protection that workers have been paying toward has included the continuation of survivors' benefits to children after age 18 and through 21 if the child attends school full time. The full-time school attendance requirement may be satisfied in high school, technical school, junior college, or regular college. Such benefits are also payable to sons and daughters of retired or disabled workers unde. the same conditions. Some 800,000

young people attending school are now receiving social security benefits to partly make up for the loss of parental support due to death, retirement, or total disability.

The ability to provide at least some help toward the continued schooling of one's children in the event one dies, retires, or becomes disabled has seemed an important protection to many, many workers. The Administration argues, however, that these social security benefits should be dropped and that the sons and daughters of deceased, retired, or totally disabled workers should look instead to the Basic Educational Opportunity Grant Program for low-income students and a revised student loan program that would have income limitations. Yet, the grant program has not been fully funded in the past, and, under the budget proposals, the funding is not increased to make up for the elimination of the social security benefit.

Given the current cost of higher education, very frequently, in any event, the social security benefit needs to be supplemented by the other programs, just as parental support from those who have not died, retired, or become totally disabled needs frequently to be supplemented by the grant and loan programs. The partial replacement of parental support by the social security benefit helps to equalize educational opportunity for these young survivors and dependents of retired and disabled workers. It is not in conflict with programs designed to supplement parental support.

This partial replacement of parent support for youths attending school seems to me a legitimate use of social insurance funds, but in the event the Congress decides otherwise, I would hope that, at least, it would not reduce benefits already being provided or eliminate the benefit for those who have had every reason to count on its later receipt. But let me return to that issue in a minute.

(c) Elimination of the lump-sum death benefit for insured workers who do not have a surviving spouse or child eligible for monthly benefits.

Social security pays a lump-sum benefit when insured workers die. The benefit is paid to the spouse who was living with the deceased worker. If the worker has no spouse, or if the worker's spouse was not living with him, the benefit is paid to the person(s) who paid the funeral expenses. The benefit is the lesser of: (a) three times the worker's primary insurance amount; or (b) $255. The dollar ceiling has been $255 since the early 1950s. In recent years, three times a worker's primary insurance amount has, in every case, been more than $255 so that all lump-sum payments have been for $255.

It is very important to many people that they leave enough insurance to provide for their burial and to pay for the expenses of their last illness. They are greatly concerned that their death not be an expense to friends, family, or relatives or that they not be buried at public expense. The current payment of $255 is clearly inadequate for this purpose, and I would favor raising the ceiling to at least $500, as proposed by the last Advisory Council. To move in the opposite direction and drop the benefit, except where there is a surviving spouse or child eligible for monthly payments, would lead many people to buy the most inefficient type of private insurance—the so-called "industrial" policies which are sold door to door, with premiums collected weekly or monthly. Because administrative expenses for such policies are very high compared to their low face value, only about one-half or even less of the premium revenues are ever paid to claimants.

Protection against the costs of last illness and funeral expenses seems to me a legitimate objective of social insurance and an efficient way of providing the protection. I believe the benefit should be improved somewhat rather than reduced in scope.

(d) Adding currently insured status to the eligibility requirements for disability insurance.

When the program was first passed, in addition to meeting the present test of fully insured status, plus having worked 20 quarters of coverage out of the 40 calendar quarters ending with the quarter in which the individual becomes disabled, a worker had to meet a test of working in 6 quarters out of the last 13. This test of recency of work was removed from the program by the Congress in 1958 because this test was preventing many totally disabled workers from getting benefits, even though they had paid into the system for a long period of time.

Many total disabilities do not occur at a precise moment in time. Unlike the person disabled in an automobile accident or by a stroke, say, a worker may suffer from a degenerative illness that just gets gradually worse. Since the definition of disability for social security purposes is very strict—inability to engage in any substantial gainful activity—a worker may be significantly disadvantaged in the labor market for a considerable period of time before he meets the definition. Thus it is not unusual to find workers with a mental illness or any one of a number of progressive diseases, such as emphysema, who have a history of intermittent employment for a considerable period before a final determination of disability can be

made. Thus under the 6 out of 13 test, by the time the individual was "disabled enough" to meet the strict definition in social security, he or she was no longer able to meet the test of recent employment.

I believe the decision to remove the test of recency was the correct one, and I believe that, if it were once again included in the program, many deserving people would be made ineligible for benefits.

The Congress made a very thorough review of the disability provisions of social security over a period of several years prior to the 1980 amendments. I see no justification for opening up this program for reexamination so soon again. Many of the provisions of the 1980 amendments have not even been given a chance to operate.

Present cost projections for the disability program show the system to be well financed, and there seems to be no good reason for cutting down on the protection now provided in order to save money.

All in all, I do not think social security policy should be made in order to gain short-term advantages for the unified budget, and this proposal seems to have no other merit.

(e) Providing that combined disability benefits from various Federal and State programs should not exceed a worker's previous earnings.

Under present law, the combined amount payable by social security and by workmen's compensation cannot exceed 80 percent of the average of the highest five years of the worker's earnings since 1950, or the earnings in the highest year out of the five years preceding the year in which the worker became disabled, whichever is higher. The earnings in these tests are automatically updated as average wages covered under social security rise. The states are given the opportunity to reduce their workmen's compensation benefits to a point where the combined workmen's compensation and social security benefits do not exceed the 80 percent test, and many states have taken advantage of this provision to do so. However, if the states do not act, then the social security benefit is reduced to accomplish the same purpose.

There are no other provisions in the Social Security Act for adjustment because of the payment of other disability benefits, but a high proportion of private pension plans do adjust their disability benefits if a social security disability payment is being made. I think they all should, but it would be a considerable departure from previous Federal policy toward private pension plans to require them to do so by Federal law, and this has not been proposed.

There is an argument from the standpoint of incentives to have an overall cap on government benefits paid for the same disability, but there is certainly also a strong point to be made on the other side—that is, the most important benefits affected by such a proposal would be veteran's compensation (not proposed for inclusion under the cap by the Administration) and payments to miners who are disabled because of lung disease. In both of these cases the argument is made with considerable merit that the payment is designed not only to make up for a loss of earning capacity, as social security is, but is also an indemnity payment for an injury. If it is thought of as an indemnity, there is not the same problem in getting more in total benefits than one might have been able to earn while at work.

In any event, if such a cap were to be considered, it seems to me of great importance that the test of earning capacity be similar to that in the present law governing the total of workmen's compensation and social security benefits rather than a test of a career average of earnings, as is used in the new provision limiting family benefits under the disability program. What counts from an incentive standpoint is the worker's demonstrated recent capacity to earn, with this test kept up to date as wages move up. An average of lifetime earnings, or even the highest earnings, stated in terms of wage levels of many years ago, is hardly a fair measure of what would currently be a level of benefits affecting incentives to work. It also seems to me that if any such cap were to be considered, the contributory social security benefit is the one that ought always to be paid in full, and that any adjustment should be in the smaller, noncontributory programs paid from general revenues. Thus, even if such a cap were to be considered, if done in the most logical way, it would have no effect on social security costs.

(f) Elimination of the provisions for reimbursing state agencies for the vocational rehabilitation of social security disability beneficiaries.

Beginning in 1967, the disability insurance fund began reimbursing the state rehabilitation agencies for the cost of rehabilitating social security beneficiaries. The provision for paying for rehabilitation out of the disability trust fund was adopted because, with limited funds available from regular rehabilitation programs, the state agencies tended to avoid the very seriously disabled social security beneficiaries in favor of those with only partial disabilities, who were easier to rehabili-

tate. From social security's viewpoint, paying for rehabilitation is a good business proposition. Every beneficiary who goes to work saves the program money.

My own view is that social security should probably spend more to get its disability beneficiaries into productive employment. I agree with the last Advisory Council's suggestion that a study should be made of using not only the state agencies but possibly private rehabilitation agencies as well.

(g) The budget also calls for stepped-up review of the continued eligibility of disabled beneficiaries.

Such stepped-up review, which I support, was provided for by the 1980 amendments to the Social Security Act. I think the Social Security Administration should be allowed to fully implement the new law without still further mandated reviews at this time.

(4) Any changes that are made should be graded in over time and not take away from those who have every reason to believe they are currently protected.—It is not enough simply to protect the rights of those already receiving benefits, although doing this would be a big improvement over the proposals of the Administration. In the case of benefits for surviving and dependent children attending school, for example, there are large numbers of widows and children who are now counting on the continuation of the child's benefit when the child goes to technical school or college. Millions of pamphlets have been sent out explaining their rights under the law. To eliminate this benefit, for say a child now 16 or 17 years old, or to eliminate the minimum benefit for a 61-year-old, say, who is counting on it next year seems to me very likely to undermine confidence in the general dependability of the system.

If such changes are to be made, and I am against them, then at least make them in a way that will cause the least resentment. Give people a chance to adjust, to make other plans. Rushing the proposals through in a way to get quick savings for the unified budget would, I believe, weaken confidence in the dependability of social security as a whole. If the government can so easily change its compact with the contributing worker without notice and without lead time in regard to these benefits, it might in future years decide to make other changes affecting millions of other contributing workers. Yet, dependability is the most essential characteristic of the system if it is to retain public support. And why should state and local employees or Federal employees want to come into social security unless they can count on the stability and predictability of the benefit promises?

(5) There should be an increased allocation of social security taxes to the cash benefit program.—The financing of social security is on a pay-as-you-go basis with most of the funds collected in a given year being paid out in benefits in that year. It is intended that there should be a contingency fund sufficient to tide the program over periods in which fluctuations in economic conditions may cause a temporary imbalance between income and outgo. While the interest earnings on such a contingency fund are useful, they do not form any substantial part of the long-range financing of the social security program.

This pay-as-you-go system can ordinarily be expected to work well. As long as increases in wages exceed increases in prices, the income to the system (determined as a percentage of payrolls) will usually be enough to cover the cost of benefit increases, which are tied automatically to price increases. Pay-as-you-go financing is also sensitive to the rate of unemployment, which, of course, also affects payroll size. Recently, the contingency funds have been drawn below a reasonably safe level because we have had the unusual combination of prices rising faster than wages and, at the same time, a relatively high unemployment rate.

It is clear that some congressional action will be needed shortly to avoid a short-term financing problem in the old-age and survivors' insurance part of socal security (the disability insurance program and the hospital insurance part of Medicare are not in difficulty). The reallocation of rates between old-age and survivors' insurance and disability insurance signed into law on October 9, 1980 was intended as a stop-gap measure and is probably sufficient only through calendar year 1981. The action required can be quite minimal, or we can take the occasion—as I think we should—to make rather fundamental changes in financing.

The Carter Administration proposed borrowing among the three social security funds—the old-age and survivors' insurance fund, the disability insurance fund, and the hospital insurance fund—as a way of meeting the short-term problem in old-age and survivors' insurance between the end of 1981 and the point at which the presently scheduled 1985 contribution rate increases take hold. If the economy improves rapidly and substantially, this provision alone might well make the present financing of the cash benefit program sufficient for the next 50 years and the financing of the hospital insurance program under Medicare sufficient at least into the 1990s. Under other economic assumptions, however, this plan would be inad-

equate in the 1984-1985 period, and Congress would once again need to address the question of social security financing.

My own view is that it would be desirable to make fundamental changes in social security financing right away so that financing of the cash benefit program would be assured at least into the next century and without having to raise the tax rate for old-age, survivors' and disability insurance for at least the next 25 years. It is very disturbing to beneficiaries and contributors alike to keep running into these short-term crises because of an insufficient margin in the short-term rates. And it is disturbing to contributors to keep facing a series of rate increases.

What I would propose is that beginning in 1982 the rate for cash benefits, OASI and DI combined, be set at 6 percent of earnings rather than the presently scheduled 5.4 percent. During 1982, hospital insurance under Medicare could be financed by the present contribution rate of 0.65 percent for the employee, 0.65 percent for the employer and a drawing down of the hospital insurance trust fund, making the overall social security tax rate for 1982 6.65 percent (the same as 1981), rather than 6.70 percent, as scheduled for 1982 in present law. Beginning in 1983, general revenues would be introduced to pay half the cost of hospital insurance. The contribution rate for hospital insurance would stay at 0.65 percent through 1984, and would be increased to 0.80 in 1985 (present law calls for an increase in the HI rate of 0.05 in 1985 and an additional 0.10 in 1986).

The 6 percent rate proposed for the cash benefit program would stay at that level for at least the next 25 years. It is to be compared with the present schedule for cash benefits of 5.35 for 1981, 5.40 for 1982-84, 5.70 for 1985-89, and 6.20 for 1990 and thereafter. The scheduled 1990 rate of 6.20 is estimated to produce very large excesses of income over outgo for at least 15 years or so after 1990, and the proposed 6 percent rate, starting in 1981, would finance the cash benefit program from 1981 well into the next century.

The idea of financing half of hospital insurance under Medicare out of general revenues is not original with me, but has been advocated for some time by Congressman Barber Conable, the ranking Republican on the Ways and Means Committee, and has now been endorsed by the National Commission on Social Security.

Perhaps because Part B of Medicare already has the major part of its cost covered by general revenue financing, and perhaps also because the benefits in both parts of Medicare are not geared to past earnings as they are in the cash benefit program, there has been less reluctance to move away from total reliance on an earnings or payroll tax in the Medicare program as compared with the cash benefit part of social security.

At the present time, the hospital insurance part of Medicare (Part A) is financed almost entirely from a tax on employers' payrolls and deductions from workers' earnings, as in the case of cash benefits under social security. The exceptions are minor: contributions from general revenues, for example, to pay for non-contributory credits for military service, and for hospital insurance benefits paid to people uninsured under social security at the time the hospital insurance program began. On the contrary, about 70 percent of the costs of Supplementary Medical Insurance (Part B) under Medicare, which reimburses for the cost of physicians' services, is paid from general revenues, and the rest of the cost is met from premiums paid currently by those insured under the program. If both Parts A and B of Medicare are looked at together, about 20 percent of the revenues for Medicare comes from general taxes.

Although what I have described is my preferred plan, there are, of course, others:

The very minimal change of inter-fund borrowing proposed by the Carter Administration would, under optimistic economic assumptions, get the cash benefit program through the next 50 years (and the hospital insurance program into the 1990s) under the contribution schedules provided by present law. If necessary, this approach could be supplemented by some advances from general revenue during the 1984-85 period, should they be needed.

Another approach would be to provide for inter-fund borrowing as proposed by the Carter Administration, but, at the same time, move the 1985 scheduled increase in the contribution rate for cash benefits to 1984. This again would be sufficient only under optimistic economic assumptions.

A plan which would have the same result for social security financing as the one I propose but which would not depend on any general revenue financing for hospital insurance, would be to provide for a direct increase of 0.65 percent in the cash benefit rate in the near future. Such an increase would, of course, take the place of the various scheduled increases for the cash benefit program in present law.

In any event, there is no need to turn to cutting benefit protection to meet the short-term financing problem in the OASI part of social security; there are any number of satisfactory ways of financing the benefit protection promised by present

law. What I have proposed has the advantages, as compared to the first two of the proposals I have just described, of not depending on either the realization of optimistic economic assumptions or an infusion of general revenues for the cash benefit program. Compared with the third proposal, it would not require an increase in social security taxes for the cash benefit program until at least well into the next century.

(6) Neither Demography Nor the Economic Future of the United States Requires Cuts in Social Security Protection.—In discussing the social security cost implications of the future demography of the United States, it seems to me of the first importance that we be clear in distinguishing between those matters we can be quite certain about and those matters which are more speculative. The broad outline of the growth in the absolute number of the elderly population over the next 50 years is quite certain—perhaps a 600,000 a year average increase in the number of those over 65 for about 15 years in the future, then a considerable slowing down in the rate of increase for 10, followed by a huge increase, averaging well over a million a year, for the following 25 years, and then a more or less leveling off for many years after 2030. The people who will become 65 between now and 2045 have already been born, and the application of expected mortality rates (which include a substantial allowance for improved mortality) to the existing population produces the results described. In other words, give or take a few million, the number of people over 65 will rise from 26 million today to 35 million by 1995, rise relatively slowly for the next 10 years, and then be followed by a huge increase in just a 25-year-period from about 37 million in 2005 to 65 million in 2030, with the number over 65 leveling off after that.

It is a fact that, for approximately the next 15 years, large numbers of people will be reaching age 65 because birth rates were relatively high in the period from 1915 to 1930. It is also a fact that the number over 65 will not increase as much for the 10 years after 1995 because of the low birth rates during the great depression. And it is a fact that the baby-boom generation of post World War II starts to reach 65 in the early part of the next century.

Much less certain is the widely held belief that shortly after the turn of the century, just at the time the number of elderly starts to increase so rapidly, the growth in the 20 through 64-year-old population—ordinarily thought of as the working age population—will come to a virtual halt and remain stable for many years. It is the possibility of the relative growth in the number of retirees compared to those at work that causes concern about long-range financing of social security. Between now and about 2005, there continues to be a major growth in the 20 to 64-year-old group—again a near certainty—so that the ratio of those over 65 to this younger age group changes relatively little during this period. Thus, there is no significant demographic problem for social security for the next 25 years at least. The proportion taking out and the proportion paying in will probably change very little.

In the longer run, however, there could be sizeable increases in the cost of social security cash benefits if we continue to have low birth rates, immigration rates limited to the present legal level, a substantial increase in the rate of disability, a work force that retires about as early as today, and a continued long-range decline in the proportion of workers' compensation paid in wages as compared to fringe benefits. These are the assumptions made in the last Trustees' Report, and on strictly a pay-as-you-go basis (no reserves) these assumptions produce a need for a contribution rate from 2025 on of about 8½ percent of earnings as compared to 6 percent or less for the rest of this century. If this turns out to be the case, however, it is of great importance to recognize that the very assumptions which produce an increasing ratio of older people to those at work also result in a declining ratio of children to those at work. If, instead of the ratio of those over 65 to those 20 through 64, we take what has been called a total dependency ratio, the ratio of those over 65 plus those under 20 to the group 20 through 65, we get a much different picture than if we look only at the elderly. It just isn't true that reasonable demographic assumptions show a larger number of dependents for each worker after the early part of the next century. Instead, what they show is a shift in the composition of the dependency group—fewer children, more elderly.

Today we have about 75 people either over 65 or under 20 for every 100 in the age group 20 through 64. Over the next 25 or 30 years, this proportion drops steadily until it reaches a low point of 68 per 100 around 2010. In other words, up to that year, there are actually fewer dependents per worker than we have now, and it takes until about 2020 to get back to where we are today. Even at the high point in the total dependency ratio in 2035, we get a ratio of only 86 per 100, as compared to 90 in 1970 and 95 in 1965. In the future people may need to shift some of the

resources that were once spent to raise children to building the kind of world they want for themselves and others in retirement.

In spite of the relative stability of the total dependency ratio, under the Trustees' assumptions the percentage of covered payroll needed to support the social security system would increase. This is true, in part, because about 80 percent of the cost of social security is for the elderly. Under the central set of assumptions used by the Trustees, some 50 years from now only two covered workers per beneficiary will be paying into the system as compared with 3.2 today. As stated earlier, this depends on assumptions that include fertility rates not rising above the rate necessary to replace the population, continuation of retirement at approximately the same early age as today, immigration held to the present legal limit of 400,000 a year, and an increase in the incidence of total disability to a level substantially higher in the future than it is today.

Another powerful assumption in the long-range cost estimates is that the percentage of payroll to cover social security costs will continually have to rise because a smaller and smaller proportion of workers' compensation is assumed to be in the form of wages as compared to fringe benefits. Yung-Ping Chen, the Research Director of the McCahan Foundation for Research in Economic Security, has pointed out that, if wages and salaries were to remain at 84.2 percent of total employee compensation as they are today, then the pay-as-you-go social security tax rate would be considerably less than presently estimated. This is true because the official estimates assume that wages as a proportion of total workers' compensation will have dropped from 84.2 percent in 1980 to 71.5 percent in 2020, to 67.4 percent in 2035, and to 62.2 percent in 2055.

All of these assumptions can be defended with varying degrees of persuasiveness, but they can also be questioned. If one goes along with what has been assumed, then the cash benefit program, kept up to date with wages and prices, can be financed well into the next century for a 6 percent contribution rate or less. In the longer run, on a strictly pay-as-you-go basis, a self-financed system would require about an 8½ percent contribution rate.

Such a rate would not be an overwhelming burden. German workers already pay 8 percent for old-age, survivors' and disability insurance protection, and, in addition, the general revenues of the German government pay for 19 percent of the cost of the system. But I am not at all sure that such a rate will be needed. No matter what assumptions are made about fertility rates, immigration, retirement age, etc., it does not make startling differences in the estimated cost of the social security system for the next 25 years. In the near term, financing problems, if any, arise from the lack of an adequate contingency reserve to see the system through major economic fluctuations. The important factors in the short run are the depth and length of recession periods, the level of unemployment and inflation, and the relation of price increases to wage increases, and the variations should be manageable with adequate contingency reserves. But for the next century, predicted costs vary widely, depending on demographic factors, whether the proportion of worker's compensation subject to social security taxes continues to decline more or less indefinitely, and on many other unpredictable trends. We just don't know very much about what will happen on many of these crucial factors some 25 to 50 years from now. We can be quite certain about the large increase in the absolute numbers of the elderly, but we really don't know very much about future fertility rates, the extent to which women in the future will work in the paid labor force rather than as homemakers, the extent to which, under conditions of fewer new entrants to the labor force, employers will offer inducements to older workers to stay on at their jobs longer than they do today, what our immigration policy will be, all the other factors which will affect the ratio of "payers-in" to "takers-out" and whether at some point workers will seek increases in current wages rather than more and more fringe benefits. We just don't know whether social security costs measured as a percentage of payrolls will significantly increase in the next century or not.

In any event, it can be expected that, over the long run, productivity increases translated into higher levels of living will make any increase in contribution rates that might be necessary easier to bear. Most people do not question some increase in productivity in the future. The argument is mainly over how large these increases will be. Even modest increases of 1¾ percent a year, on the average—for example, the Trustees' assumptions of a 4 percent annual price increase and a 5¾ percent wage increase over the long run (a much lower percentage increase than the 2 to 2.5 percent which, up until recently, has been the historical average)—translate into a doubling of real wages after social security taxes by about 2025. As a percentage of GNP, social security cash benefits, according to the intermediate estimates of the Board of Trustees, gradually drop from 5.05 next year to 4.30 by 2003, and then rise to a peak of 6.36 in 2030, falling again to 5.82 in 2055. It seems

to me quite wrong to consider making reductions in social security protection *now* based on the notion that in the distant future the costs of the present social security law will somehow become much more difficult to support. This is not likely to be the case.

In summary, there is no reason to expect that in the long run the economic burden supporting the present social security law will be greater than it is today: (1) It is not at all clear whether, and to what extent, there will actually be an increase in the ratio of those drawing benefits to those paying in. (2) In terms of the basic economic situation in the future, there will not be more dependents per worker than there were, say, in 1970—there will be more older people but fewer children. (3) It can be expected that the real wage level will be much larger in the long-range future than it is today—perhaps about twice as high by 2025 after social security taxes—so that any increase required in social security contributions would be much easier for workers in the future to bear. (4) Under present law, social security benefits as a percentage of gross national product (using the assumptions in the middle-range estimates of the latest Trustees' report) show a considerable drop between now and the early part of the next century and a relatively small increase thereafter—in the range of 5.05 next year, 4.30 shortly after the turn of the century, 6.36 in 2030, and 5.82 in 2055. (5) Finally, the decrease in the part of workers' compensation subject to social security taxes may well have been exaggerated.

CONCLUSION

All in all, I believe that the social security system that emerged from the 1977 amendments is a good one. The most recent polls show clearly that social security is a popular program, that the majority of people do not favor cuts in benefits, and that, if necessary, they are willing to pay higher social security taxes to support the level of protection now provided. People just do not react to social security taxes as they do to other taxes since social security taxes are earmarked for specific protection, and they do not react to social security benefits as they do to other government expenditures because they see the benefit resulting from a compact between the government and the contributor.

The major task in legislation for social security is to strengthen public confidence in the system's financing, in the dependability of the benefit payments, and in the intention of the government to honor the commitments that have been made. Social security continues to be immensely popular, but the reports of fiscal crisis and bankruptcy, the proposals to suddenly cut back on benefits that people have been counting on, and the failure of government to make clear that the self-financed system of social security cannot appropriately be manipulated for short-term budget objectives are contributing to weakening the public's confidence in the system.

The CHAIRMAN. I am going to ask, if no one objects, that the next witness by Jan Deering, board of directors of the Association of Junior Leagues.

Jan, are you prepared and ready to go?

Following that, we will have a panel consisting of Mr. Hacking and Mr. Clayman.

I might indicate as I have to other witnesses, your entire statement will be made a part of the record.

You may proceed in any way you wish.

We are happy to have you here.

STATEMENT OF JAN DEERING, MEMBER OF BOARD OF DIRECTORS, THE ASSOCIATION OF JUNIOR LEAGUES, INC.; ACCOMPANIED BY SALLY ORR, DIRECTOR OF PUBLIC POLICY OF THE ASSOCIATION OF JUNIOR LEAGUES, INC.

Ms. DEERING. Thank you. It is a pleasure to be here and a privilege, particularly in light of the support that you have shown the children of our State of Kansas, as well as those throughout the Nation.

Accompanying me this morning is Sally Orr, director of public policy for the Association of Junior Leagues.

I am here today on behalf of the association to request your continued support for the child welfare reforms and subsidized adoption provisions included in the Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272, passed by the 96th Congress.

We strongly urge you to maintain titles IV-B and IV-E of the Social Security Act separate from the block grants for social services proposed by President Reagan.

We also ask that you recommend adequate funding for these programs. Specifically, we urge you to recommend an appropriation of $220 million for title IV-B for fiscal year 1982.

The Association of Junior Leagues is an international women's volunteer organization with 235 member leagues in the United States, representing approximately 132,000 individual members.

The junior leagues promote the solution of community problems through voluntary citizen involvement, and train their members to be effective voluntary participants in their communities.

The association's commitment to the improvement of services for children is long standing. Junior league volunteers have been providing services to children since the first junior league was founded in New York City in 1901.

Many of the experiences of individual junior leagues advocating for reforms in their communities made them aware of the need to move for reform at the Federal level.

Often the difficulties that junior league advocates encountered were caused by Federal fiscal policies that encouraged family breakup by providing easy access to foster care funds while providing little or no funding for preventive programs that would help families to remain together.

There were also no Federal funds available to encourage adoption of children with special needs.

The growing awareness for the need for change at the Federal level led the delegates to the association's 1978 annual conference to vote that the association should advocate to see that opportunities and services essential for the optimal, physical, intellectual, emotional, mental and social growth of children are provided.

In 1979, the association moved to fulfill this mandate by voting support of legislation in child welfare reform and child health and establishing a legislative network to secure passage of legislation in these areas.

To date, 194 junior leagues, 21 State public affairs committees and 1 regional council have joined the network.

Junior leagues across the country continue to work for foster care reform and the development of subsidized adoption programs.

Their support of child welfare reform and a subsidized adoption program at the Federal level stems from their knowledge of the stimulus that carefully targeted Federal programs can be for needed reforms at the State and local level.

My own junior league, the Junior League of Wichita, completed an extensive survey of community services for children in 1975, subsequently focusing on the need for foster care reform.

A position statement on foster care adopted by the Junior League of Wichita in 1978, and reaffirmed annually since then by the league, calls for many of the reforms mandated by Public Law

96-272. Similar position statements have been adopted by the two other junior leagues in Kansas, Topeka and Kansas City, Kans., as well as the State public affairs committee of the Junior Leagues of Kansas, which represents the approximately 1,500 junior league members in the States.

I have copies here with me of these position statements should you be interested in seeing them.

In 1978, the three junior leagues of Kansas joined with the Kansas Children's Service League, a statewide not-for-profit agency that provides a wide range of services to children, to establish the Kansas Action for Children, a statewide advocacy group.

The Kansas Action for Children monitors the delivery of services to children and publishes "Action for Children's Sake," a weekly legislative news sheet focusing on legislation affecting children, that is sent to over 3,500 individuals and organizations in the State of Kansas.

All three junior leagues in Kansas worked actively for the passage if Public Law 96-272. Our experiences have shown the need for the reforms mandated by the child welfare and adoption assistance sections of that legislation.

Of the more than 4,700 children in foster care in Kansas, 402 of these children have been in foster care for more than 8 years.

I was amazed at the difficulty I had getting these statistics and I personally feel that this information should be for public record.

Although Social and Rehabilitative Services of Kansas adopted a permanency planning project in January 1980 for children in placement over 1 year, the opportunities for the type of permanency we seek for children are very slim for older children in our State.

In fact, caseworkers speak of a stagnant population that was passed over 10 years ago. We know from the work of national groups that homes can be found for children, including those with special needs.

In Kansas, however, of the 201 children placed for adoption in 1980, less than 10 percent were over 11 years old. Furthermore, intake for the State's 9-year old adoption sibsidy program was closed last month because of lack of funds.

At this very moment in Kansas, 10 children for whom adoptive families have been approved remain unadopted and in foster care because there are no funds for subsidy.

Implementation of the subsidized adoption program mandated by Public Law 96-272 would give these children permanent homes and permanent families.

Kansas has no regular judicial or independent review for children in foster care. Experiences with foster care review systems in other States indicate that regular reviews such as those required in Public Law 96-272 result in achievement of permanency for children either by reuniting families, or when this is not possible, terminating parental rights freeing the child for adoption.

We are certain that many of those children who have been in foster care for the past 8 years would be in permanent homes today if Public Law 96-272 had been enacted earlier.

Kansas Social and Rehabilitative Services is predicting a 300-percent increase next year in confirmed child abuse cases. If services are not available to help these families, the children inevitably

will end up in foster care at considerable expense to the taxpayer and emotional distress to the child.

The work of other junior leagues has highlighted the need for the development of the prevention and reunification required by the child welfare reform sections of Public Law 96-272.

For instance, eight junior leagues in California played an active role in the passage of their State's family protection act, legislation that provided for a 4-year demonstration project involving State and county financial cooperation to provide services to prevent the removal of children from their homes either voluntarily or by the juvenile court.

Demonstration projects have been established in San Mateo and Shasta Counties.

Representatives of the San Francisco and Palo Alto junior leagues, two of the eight junior leagues that supported passage of the FPA, serve on the evaluation committee for the project. The effects of the demonstration project have been dramatic in San Mateo County.

According to a member of the Palo Alto Junior League who serves on the evaluation committee, there was a 33-percent decrease in the admissions to foster homes and institutions in the 3-year period from September 1977 to September 1980.

This significant drop came at a time when the reduction in out-of-home placements statewide was only 1 percent.

One of the services offered by the San Mateo project is respite care.

My experience, as a speech pathologist during the past 20 years, has made me acutely aware of the critical need for respite care. I have known many caring parents of handicapped children who, because they have never been able to be away from their children for any length of time, have broken under the daily strain. They either become abusive or found it necessary to place the children in foster care, or both.

Advocacy groups across the country can also attest to the need for the type of subsidized adoption programs provided by the new title IV-E of the Social Security Act.

Junior leagues in New Jersey have played key roles in securing the passage of these programs which promise to provide permanent homes for some of this country's neediest children.

The support provided by the junior leagues of Oregon for a national subsidized adoption program predates the association's support for such a program.

The two junior leagues in Oregon, Eugene and Portland, worked for the passage of H.R. 7200 in the 95th Congress. The junior leagues of Oregon also have worked actively to increase the financial support of their State's subsidy program.

In summary, the child welfare and subsidized adoption programs provided by Public Law 96-272 provide a cost-effective method of providing permanency for children.

The programs mandated by the new law are among the most supportive family measures before the Congress.

They offer services to prevent family breakup and to reunify families that have been separated.

When reunification is impossible, they offer a subsidized adoption program to provide permanent homes for children who would otherwise be homeless and for whose care and support the Government would otherwise be responsible.

This landmark piece of legislation passed by the House by a vote of 401 to 2 and received unanimous approval in the Senate only 8 months ago. We urge you to give it a chance to prove itself by keeping titles IV-B and IV-E of the Social Security Act out of any block grant and by calling for funding adequate to trigger the reforms mandated in the law.

Many have spoken of children as our Nation's most precious resource. We firmly believe they are.

Further, we know that children toward whom the reforms included in Public Law 96-272 are directed are among our Nation's neediest.

They are not only needy, but they are without a vote and a voice. We urge you not to abandon the reforms that would make it possible to provide permanent homes for them.

Please do not let the brunt of budget cuts fall on the neediest of our Nation's children.

Thank you, again, for the opportunity to appear before you.

The CHAIRMAN. Well, I would just say that in light of the legislation passed last year, we are certainly sympathetic. In fact, I think I asked Secretary Schweiker, when he was here, to take a look at eliminating this from the block grant proposal.

I have not yet had a response from the Secretary.

On the other hand, we are caught in a budget crunch here that makes it very difficult. I wouldn't anticipate any new programs passing the Congress this year. I think there may be certain efforts to ease the impact some. But, again, at this point, I'm not certain just what the committee may finally do.

There is a lot of support of this program obviously in that it passed the Congress with the lopsided margin it did, but there is also a lot of support for ending 17-percent interest rates, 12-percent inflation, overregulation, and high unemployment. You can't have it both ways, but we will do the best we can.

I'm certain that Senator Moynihan will do the same.

Ms. DEERING. There are 500,000 children in foster care in the United States of America. I hope that we will all consider what the implications of this might be if permanent homes aren't found for most of these children in the future in regards to unemployment in our country and a lot of other welfare problems.

The CHAIRMAN. How much are we spending on a State level?

Ms. DEERING. Which particular State are you referring to?

The CHAIRMAN. Kansas.

Ms. DEERING. In Kansas, can you address that point?

Ms. ORR. I do not have the figures on that. We will check, but, Jan, as she said, had quite a bit of difficulty finding out how many children are in foster care and so we will do the best we can on getting the statistics to you.

Ms. DEERING. I do know that once the children are placed, the cost in placing them in permanent homes is much less than being in foster care for 8 years or 10 years, or 3 years, or whatever, as

well as those children that end up in incarcerating institutions and we are spending our money that way.

The preventive medicine is so vital here.

Ms. ORR. Subsidized adoption program, for instance, always the payment is less than the foster care rate.

Ms. DEERING. Absolutely.

Ms. ORR. Plus there is no supervision of the social worker once the adoption is finalized.

Second, if the child should go into an institution, of course, it goes to $18,000 to $30,000 per year.

Senator Moynihan spoke eloquently of the AFDC children. Many of these children who are in AFDC foster care would not have to go under foster care if some of these services were available, and they are cheaper in the long run.

The four Republicans on the Public Assistance Subcommittee and Congressman Conable, in their letter to Secretary Schweiker, spoke eloquently of this. That it is often cheaper for a State to put a child in foster care if they aren't planning past the next year, and they are worried, so in a crisis crunch, they don't do the long-range planning.

But these services, as we spoke in our testimony, for instance, for California are proving cost-effective in the long run because if you can get a homemaker in, or as Jan mentioned that she has found in her work as a speech pathologist that a family that can get respite care can stay together sometimes. But if everything goes to pieces and the children are taken out, it is much more expensive. And once the family breaks up, it is much harder to get the family back together.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman, and let me thank you, Ms. Deering.

I just want to repeat that I am surprised how few persons come forward to speak to this matter. We have an empty press table, of course, and practically an empty room. I thought I had come to the wrong place this morning when there were no lines outside.

We are not dealing with commodity tax squabbles, so there is no possible interest of the lobbyists, but good for the junior league. You won't mind my saying that I was the author of the Child Adoption Act and I did so out of a certain amount of experience in the State of New York.

We have had adoption support for about 16 years and it works, but it is, at some measures, sweeping back to sea. You might have heard from the chairman that we have now got perfectly—I mean as good as numbers as you are likely to get, typically HEW or HHS, whatever it is now, would do. About a third of the children born today will be living on AFDC before they are—reach their maturity.

That, obviously, means the social system is not working very well. It's not working. And, I think, it is only as we begin to perceive how badly it's working, that the only people still willing to come here and talk about it are like the junior league, who have been at it a long time.

An awful lot of people just stay away from it now. It is just too much of a problem—too big.

But what kind of a society is it in the wealthiest society of the history of the world in which a third of the children will be on public assistance before they are 18?

I mean, you know, what happened here?

Well, we will do our best for you. As I said, the chairman has problems, of course, and it is not the easiest thing to have a friend and a constituent from Kansas come in here and tell you: stop that crazy administration before it does all these awful things.

But, you know, you have a very humane and a very wise man as Chairman——

Ms. DEERING. He cares about children.

Senator MOYNIHAN [continuing]. And he cares about children very much.

We thank you, Ms. Deering.

Ms. DEERING. Thank you very much.

The CHAIRMAN. Thank you very much. We are happy to have you and have a good trip home.

[Statement follows:]

SUMMARY

The Association of Junior Leagues urges that the Senate Committee on Finance keep Titles IV-B and IV-E of the Social Security Act separate from the block grants for social services proposed by President Reagan and recommend funding for these programs that will enable states to implement the reforms mandated by P.L. 96-272.

I. The Association:

(A) International women's volunteer organization;

(B) 235 Junior Leagues; 132,000 members in the United States;

(C) Promotes solution of community problems through voluntary citizen involvement and trains Junior League members to be effective voluntary participants in their communities.

II. Association's Child Advocacy Program:

(A) Junior Leagues in 214 communities surveyed the state of children's needs and services available to them in 1975-1976;

(B) National Training Institute on Child Advocacy held in Baltimore in 1976;

(C) Junior League experiences at local levels led to decision to support legislation at national level in child welfare and child health.

III. Association Support of Child Welfare Reform:

(A) Experiences of Junior Leagues across the country attest to need for reform of foster care system, development of preventive and reunification services and subsidized adoption program;

(B) Individual Junior Leagues and Association support child welfare provisions of Title IV-B of the Social Security Act and subsidized adoption portions of Title IV-E;

(C) Legislative Network established—194 Junior Leagues, 22 State Public Affairs Committees and one Regional Council belong to network.

IV. Association Opposes Block Grant Approach for Titles IV-B and IV-E of Social Security Act:

(A) Block grant approach would destroy reforms mandated by child welfare services sections of P.L. 96-272 and terminate subsidized adoption program;

(B) P.L. 96-272 received strong bi-partisan support, passing the Senate unanimously and the House by 401 to 2 after five years' effort by child advocates. Proposed reforms deserve chance to be tested.

I am Jan Deering, of Wichita, Kansas, a member of the Board of Directors and incoming Public Policy Chairman of the Association of Junior Leagues. I am here today on behalf of the Association to request your continued support for the child welfare reforms and subsidized adoption provisions included in the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) passed by the 96th Congress. We strongly urge you to maintain Titles IV-B and IV-E of the Social Security Act separate from the block grants for social services proposed by President Reagan. We also ask that you recommend adequate funding for these programs. Specifically, we urge you to recommend an appropriation of $220 million for Title IV-B for Fiscal Year 1982.

The Association of Junior Leagues is an international women's volunteer organization with 235 member Leagues in the United States, representing approximately 132,000 individual members. The Junior Leagues promote the solution of community problems through voluntary citizen involvement, and train their members to be effective voluntary participants in their communities.

THE ASSOCIATION OF JUNIOR LEAGUES AND ADVOCACY FOR CHILDREN

The Association's commitment to the improvement of services for children is longstanding. Junior League volunteers have been providing services to children since the first Junior League was founded in New York City in 1901. Through the years, Junior League volunteers have provided a variety of direct services to children, including the establishment of settlement houses, emergency shelters and day care centers, and have served in a variety of positions such as tutors, case aides and counselors.

In the early 1970's, a decision was made to supplement the Junior Leagues' services by broadening the Association's activities to include advocacy on behalf of children. As a first step in its advocacy efforts, the Association, in 1975, developed a study to be conducted by Junior Leagues in their own communities to determine the state of children's needs and the services available to meet them. Surveys were conducted in 214 communities by Junior League members trained in interviewing techniques and educated in the five focus areas chosen for the Association's Child Advocacy Program: child health, child welfare, special education, day care and juvenile justice.

In the area of foster care, a compilation of 70 completed surveys revealed an urgent need to overhaul the system that administers foster care in order to provide a sense of permanency in children's lives. The survey results highlighted the need to provide services designed to help reunite children in foster care with their families or, when reunification with natural parents was not possible, to move toward termination of parental rights so that a child may be freed for adoption. First and foremost, of course, was the need to provide services to keep families together and to avoid the use of foster care whenever possible.

The Association's child advocacy program was officially launched at a four-day national training institute on child advocacy in Baltimore in 1976. With technical assistance from the Association, individual Junior Leagues developed a variety of advocacy programs ranging from the design of parenting courses and educational campaigns on child abuse to supporting legislation for subsidized adoption and foster care review systems.

At the request of their local judges, several Junior Leagues initiated Children in Placement Projects (C.I.P.) in their communities. C.I.P. is a program sponsored by the National Council of Juvenile and Family Court Judges that utilizes volunteers to screen foster care cases for the courts. The goal of the program is to ensure that the case of every child in foster care is reviewed by a court at least once a year. The annual reviews are designed to end the "drift" of foster care by either reuniting the child with his family, or if this is not possible, freeing the child for adoption.

Among the Junior Leagues that have assisted in developing and staffing C.I.P. projects in their communities are the Junior Leagues of Brooklyn, New York; Oklahoma City, Oklahoma; Providence, Rhode Island; Wilmington, Delaware; and Raleigh, North Carolina. In addition, the Junior League of Wilmington, Delaware and the eight Junior Leagues in New Jersey played key roles in securing passage of legislation mandating the establishment of citizen foster review boards in their states.

Many of the experiences of individual Junior Leagues advocating for reforms in their communities made them aware of the need to move for reform at the federal level. Often the difficulties that Junior League advocates encountered were caused by federal fiscal policies that encouraged family breakup by providing easy access to foster care funds while providing little or no funding for preventive programs that would help families to remain together. There also were no federal funds available to encourage adoption of children with special needs.

ASSOCIATION SUPPORT OF CHILD WELFARE REFORM

The growing awareness of the need for change at the federal level led the delegates to the Association's 1978 Annual Conference to vote that the Association should advocate to see that opportunities and services essential for the "optimal physical, intellectual, emotional, mental and social growth of children" are provided. In 1979, the Association moved to fulfill this mandate by voting support of legislation in child welfare reform and child health and establishing a legislative network to secure passage of legislation in these areas. To date, 194 Junior Leagues,

22 State Public Affairs Committees and one Regional Council have joined the network.

The Association presented written testimony on behalf of child welfare reform to this committee in the 96th Congress and testified before the Subcommittee on Public Assistance and Unemployment Compensation of the House Ways and Means Committee in both the 96th and 97th Congress (March 12, 1981).

JUNIOR LEAGUES SUPPORT CHILD WELFARE REFORM

Junior Leagues across the country continue to work for foster care reform and the development of subsidized adoption programs. Their support of child welfare reform and a subsidized adoption program at the federal level stems from their knowledge of the stimulus that carefully-targeted federal programs can be for needed reforms at the state and local level.

Testifying before the Subcommittee on Public Assistance and Unemployment Compensation of the House Ways and Means Committee in the last session of Congress, a representative of the Junior League of Wilmington, Delaware stated: "Lobbying experience with Delaware's General Assembly has taught us that our state legislators look first to the federal government for procedural guidelines and availability of funds in deciding the validity of proposed legislative reforms. In the area concerning the achievement of a permanent home for children in foster care, there are no federal precedents which would serve as incentives and models for states.

"We need these procedural reforms to alleviate foster care 'drift', to stop unnecessary and inappropriate placements, and to end the unnecessary years spent in care by hundreds of thousands of foster children."

"We need federal fiscal incentives for states to provide reunification-of-family services, programs emphasizing prevention rather than crisis intervention, review and tracking systems, and adoption subsidies."

The Junior League of Wilmington reviewed the cases of 650 children in New Castle County, Delaware. Their profile of "Jenny", the average child in foster care in New Castle County, is illustrative of the findings about the approximately 500,000 children now in foster care in this country.

Statistics on "Jenny"

Age upon entering care: 5.8 years; Reason for entering care: neglect; Father: unknown, or not living with family; Mother: between 26–40 years of age, unemployed, emotionally troubled; Siblings: at least one brother/sister, also placed in care, but not in the same foster home with "Jenny".

Services offered to mother: a variety, but she either did not take advantage of them, or discontinued them, ~~possibly~~ due to a transportation problem or the inappropriateness of the services available; Mother's visits with "Jenny": ranging from infrequent to no contact; Current age of "Jenny": 13 years: "Jenny" has spent in foster care: 7.2 years; Number of moves by "Jenny" in foster care: 2.9, which means that "Jenny" has had to adjust to three different homes and families—statistically, she will be moved again in two months' time.

Initial placement goal: return to own mother; Current placement goal: permanent foster care.

SUPPORT OF KANSAS JUNIOR LEAGUES FOR CHILD WELFARE REFORM

My own Junior League, the Junior League of Wichita, completed an extensive survey of community services for children in 1975, subsequently focusing on the need for foster care reform. A position statement on foster care adopted by the Junior League of Wichita in 1978, and reaffirmed annually since then by the League, calls for many of the reforms mandated by P.L. 96–272, including the development of subsidized adoption programs, regular case review of children in foster care and the development of services to prevent the removal of children from their homes as well as services to help reunite families that have been separated. The Junior League of Kansas City's position statement on children, enacted in 1979, and the position statement on child abuse and neglect, adopted each year since 1977 by the Junior League of Topeka, call for similar reforms. In addition, the State Public Affairs Committee of the Junior Leagues of Kansas, representing the approximately 1,500 Junior League members in the state, has adopted a position statement calling for appropriate temporary and long-term foster care facilities, the expansion and upgrading of services for abused and neglected children and their families and, because we are well aware that services do not come free of charge, adequate funding for these services.

In 1978, the three Junior Leagues in Kansas joined with the Kansas Children's Service League, a state-wide not-for-profit agency that provides a wide range of services to children, to establish the Kansas Action for Children, a state-wide advocacy group. The Kansas Action for Children serves as a neutral monitor of existing and non-existing systems in the delivery of services to children and publishes "Action for Children's Sake," a weekly legislative newssheet focusing on legislation affecting children that is sent to 3,500 individuals and organizations in the State of Kansas.

All three Junior Leagues in Kansas worked actively for the passage of P.L. 96-272. Our experiences have shown the need for the reforms mandated by the child welfare and adoption assistance sections of that legislation. Of the more than 4700 children now in foster care in Kansas, 402 have been in foster care for more than eight years. Although the Social and Rehabilitative Services of Kansas adopted a permanency planning project in January 1980 for children in placement over one year, the opportunities for the type of permanency we seek for children are very slim for older children in our state. In fact, caseworkers speak of a "stagnant population that was passed over ten years ago." We know from the work of national groups such as the North American Center for Adoption of the Child Welfare League of America that homes can be found for older children, including those with special needs.

In Kansas, however, of the 201 children placed for adoption in 1980, less than ten percent were over 11 years old. Furthermore, intake for the state's nine-year-old adoption subsidy program was closed last month because of lack of funds. At this very moment in Kansas, ten children for whom adoptive families have been approved remain unadopted and in foster care because there are no funds for subsidy. Implementation of the subsidized adoption program mandated by P.L. 96-272 would give these children permanent homes and families.

Kansas has no regular judicial or independent review of children in foster care. Experiences with foster care review systems in other states indicate that regular reviews such as those mandated by P.L. 96-272 result in achievement of permanency for children either by reuniting families or, when this is not possible, terminating parental rights, freeing the child for adoption. We are certain that many of those children who have been in foster care for the past eight years would have permanent homes today if P.L. 96-272 had been enacted earlier.

NEED FOR PREVENTIVE/REUNIFICATION SERVICES

The work of other Junior Leagues has highlighted the need for the development of the preventive and reunification services required by the child welfare reform sections of P.L. 96-272. For instance, eight Junior Leagues in California played an active role in the passage of their state's Family Protection Act (FPA), legislation that provided for a four-year demonstration project involving state and county financial cooperation to provide services to prevent the removal of children from their own homes either voluntarily or by the Juvenile Court. Demonstration projects have been established in San Mateo and Shasta counties.

Representatives of the San Francisco and Palo Alto Junior Leagues, two of the eight Junior Leagues that supported passage of the FPA, helped develop and continue to serve on the FPA Evaluation Committee of the San Mateo County Department of Health and Welfare's Family and Children's Services Advisory Committee. Members of the committee are charged with evaluating the act and reporting to the San Mateo Board of Supervisors. The effects of the demonstration project have been dramatic in San Mateo County.

According to Ann Latta, the Palo Alto Junior League member who serves on the evaluation committee, there was a 33 percent decrease in the admissions to foster homes and institutions in the three-year period from September 1977 to September 1980. This significant drop came at a time when the reduction in out-of-home placements state-wide was only one percent. Most importantly, in 1975, before the project was initiated, 47 percent of the children placed out-of-home that year were still in placement two years later. Of the children placed in 1978, only 23 percent were still in placement.

Mrs. Latta states that the story of Sheila represents the type of services that the demonstration project has used to prevent the removal of children from their homes. Sheila was reported as an abused child to the San Mateo Social Services division of the Department of Public Health and Welfare. Investigation showed that both she and her brother were abused by their father and mother. Before the project was established, both children would have been placed out of their home. The provision of marital counseling and after-school respite care allowed Sheila and her brother to stay at home. After six months, the family was able to manage without additional social services.

Respite care and marital counseling are just two of the preventive services offered by the San Mateo project. Other family support services include: in-home caretaker, homemaker, emergency housing, parent support groups, legal representation for children in abuse and neglect cases, and emergency medical care and diagnosis.

The Junior League of Oakland-East Bay, another of the eight Junior Leagues that supported passage of California's Family Protection Act, was instrumental in the development of the Family Stress Center in Contra Costa County. The center, founded in 1978, provides parent education classes, family therapy, counseling, respite care and parent aides. The Junior League of Oakland-East Bay provided approximately $36,000 in seed money for the establishment of the center and Junior League members serve on the center's board and as volunteers in all the center's programs. Approximately one-quarter of the 1300 individuals who participated in the center's programs since it was officially established in June 1979 were referred by the children's protective services of Contra Costa County.

A significant number of those persons participating in the programs have children in foster care and are working with the center to prepare for their children's return home.

The reforms mandated by P.L. 96-272 will help California and other states develop and expand the type of reforms made possible by the San Mateo demonstration project and will stimulate the development of projects such as the Family Stress Center. Advocacy groups across the country also can attest to the need for the type of subsidized adoption program provided by the new Title IV-E of the Social Security Act. In state after state, subsidized adoption programs have provided the means for finding permanent homes for children with special needs. Junior League advocates have played a key role in initiating and securing passage of those programs which promise to provide permanent homes for some of this country's neediest children.

In fact, the support provided by the Junior Leagues of Oregon for a national subsidized adoption program pre-dates the Association's support for such a program. The two Junior Leagues in Oregon—Eugene and Portland—worked for passage of H.R. 7200 in the 95th Congress. The Junior Leagues of Oregon also have worked actively to increase the financial support of their state's subsidy program. A study of the adoption subsidy programs in 27 states completed by the Junior League of Eugene, Oregon and presented to the Oregon State legislature found significant cost savings in the subsidy programs and also revealed that the subsidized adoption programs were providing permanent homes for many children who otherwise would remain in foster care for years.

NEED FOR TITLES IV-B AND IV-E

In summary, the child welfare and subsidized adoption programs provided by P.L. 96-272 provide a cost-effective method of providing permanency for children. The programs mandated by the new law are among the most supportive family measures before this Congress. They offer services to prevent family breakup and to reunify families that have been separated. When reunification is impossible, they offer a subsidized adoption program to provide permanent homes for children who would otherwise be homeless and for whose care and support the government would otherwise be responsible.

This landmark piece of legislation passed the House by a vote of 401 to 2 and received unanimous approval in the Senate only eight months ago. We urge you to give it a chance to prove itself by keeping Titles IV-B and IV-E of the Social Security Act out of any block grant and by calling for funding adequate to trigger the reforms mandated in the law.

Many have spoken of children as our nation's most precious resource. We firmly believe they are. Further, we know that the children toward whom the reforms included in P.L. 96-272 are directed are among our nation's neediest. They not only are needy, but are without a voice. We urge you not to abandon the reforms that would make it possible to provide permanent homes for them. Please do not let the brunt of budget cuts fall on the neediest of our nation's children.

Thank you for the opportunity to appear before you today.

JAN DEERING,
Member, Board of Directors,
The Association of Junior Leagues, Inc.

The CHAIRMAN. Mr. Hacking, Mr. Clayman, and anyone else you may have with you. If it is all right with Senator Moynihan, I need to step outside just for a minute. Could you please take over?

Senator MOYNIHAN. Good morning.

Mr. Hacking, we welcome you, and Mr. Clayman. Do you have two associates with you, or one each, or would you introduce them to the committee?

Mr. HACKING. Yes, Mr. Chairman, on my left is my colleague, Mr. Ron Hagen. He is our association's health policy expert.

Senator MOYNIHAN. Good morning, sir.

Mr. Clayman, have you an associate?

Mr. CLAYMAN. Oh, excuse me. I was looking at my notes to be prepared.

Senator MOYNIHAN. Would you introduce your associate?

Mr. CLAYMAN. Betty Dustin, our research director for National Council of Senior Citizens.

Senator MOYNIHAN. Good morning and welcome.

Mr. Hacking, I think you appear first.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, D.C., ACCOMPANIED BY RON HAGEN, HEALTH POLICY EXPERT OF THE ASSOCIATIONS

Mr. HACKING. Thank you, Mr. Chairman.

I am here representing both the National Retired Teachers Association and the American Association of Retired Persons.

As I am sure you are aware, these organizations are affiliated and have a combined membership in excess of 12½ million older persons.

I would like to have my statement included in the record of the hearing. There is a summary of that statement and I'd ask that that, too, be included.

Senator MOYNIHAN. Of course, we will do that. You proceed in your manner.

Mr. HACKING. I would like to proceed from an outline that I have prepared. I would begin by saying here, as we have been saying in every forum available to us, that the chief concern of the elderly today, as it has been for some years, is inflation.

High rate, sustained inflation has been rapidly eroding all of the income components that comprise the elderly's total income, especially those components that are not indexed. As a result, the elderly over the past several years have been gradually pushed down the income distribution scale and are now, I think as Mr. Ball described quite accurately earlier, in a very, very vulnerable situation—hovering just above the poverty line and likely to be very harshly and seriously impacted by any kind of cap or limit that might be imposed on the indexing provisions of the major entitlement programs.

Over the past decade, again as I am sure you are aware, Mr. Chairman, the elderly have become increasingly dependent on Government programs that provide them with income support and health care protection.

That trend is very ominous, especially if it continues on out into the future given the demographic shift in the population.

So, given that situation, these associations have been very supportive of efforts of bringing the inflation rate down to tolerable levels. We think a multifaceted approach to the problem is neces-

sary, and in that approach we see a role for balancing of the Federal budget. We support bringing the Federal budget into balance in the near term, but we also think that that effort has to be complemented by a number of other essential elements.

We think that the money supply growth, for example, has to be brought into line with real growth in the economy. We still see a need for a tough "incomes" policy to complement these other features of an anti-inflation program to deal directly with the wage-price spiral that is the major factor right now contributing to the aggregate double digit inflation rate.

I would like to turn now to the issue of the budget and, specifically, to the administration's proposals that impact upon the programs that serve the elderly.

First, with respect to the social security cutbacks that the administration has advanced, I would just have to say, in agreement with Mr. Ball, that regardless of the merits of each of these particular cutbacks, we have to oppose them because their effect would be immediate. They are not proposed to be introduced or implemented on a prospective basis; rather they are proposals that would impact upon people who are already on the rolls and to us that amounts to a change-in-the-rules-of-the-game on people at the last minute without giving them sufficient time to prepare themselves and accomodate themselves to the changes.

We cannot accept proposals that have this sort of immediate impact. However, we do see, as part of a comprehensive long-range restructuring of social security, a role for these kinds of proposals. We think they ought to be considered on their merits in that context.

As a matter of fact, our associations have long advocated a major long-term structuring of social security to deal with the economic and demographic trends that confront the system now and that combine to produce a very large and significant long-range financial imbalance in the programs.

So, we would not oppose these proposals if they were introduced on a prospective basis and were part of a long-range restructuring of the programs.

Having said that, I would also like to add that even if this package of short-term social security cash benefit program cuts were enacted, we do not by any stretch of the imagination believe that the "savings" they would effect would be sufficient to get the programs through the near term.

We think that social security is faced with a very serious short-term financial problem, as well as a very serious long-term problem and that much more is going to have to be done beyond what the administration has advanced to date just to deal with what confronts the system in the immediate future.

Now, with regard to the curtailments in the health program area, I would have to say that we have no choice but to oppose the so-called medicaid cap. We find that if the States can't make up a shortfall in funding from their own resources—and we understand that about 26 of the States already have deficits in their medicaid programs—they are going to be forced to cutback on eligibility criteria, benefits, and/or reimbursement rates. That is simply going to deny access to needed services, or cause a further deterioration

in the quality of care that is being received by elderly people who are part of the medicaid population and who reside in nursing homes.

The cap is going to make it also less likely that the States, through their medicaid programs, will be in a position to promote the growth and expansion of community-based means of delivering health services, especially home health services and other kinds of services that represent a less costly alternative to institutionalization.

With regard to the administration's proposals in the medicare program area, we are opposed to the administration's proposed recisions with respect to the home health care liberalizations that were part of last year's Omnibus Budget Reconciliation Act.

Recision of these home health benefit improvements, we think, goes in the wrong direction. We need to start to develop a viable long-term care program that will provide a complete continuum of services, especially home health and other community-based services that will represent less costly alternatives to the institutions and give people the option of remaining in their homes.

This is why we supported last year the bill introduced by Senators Packwood and Bradley to establish a new title XXI, 10-State, 6-year demonstration project. We hope that legislation will be reintroduced and that it will be favorably considered by this committee.

Senator MOYNIHAN. Now, Mr. Hacking, you were doing very well until you got there. It is a problem of credibility in a witness if you think that there is going to be any new legislation out of this Congress. [Laughter.]

Mr. HACKING. Well, Senator, the emphasis in health care right now is on acute care intervention and on institutionalization.

We need to know what would happen in terms of overall cost if we put a focus on case management and assessment and utilize community-based services that would represent, we hope, less costly alternative to institutionalization. If we can do this on a demonstration project basis, then—at very modest cost, we will have the data which we must have before we can go on to implement something on a nationwide basis.

But the point here is this: We have to find some means for setting up some alternatives to the current structure of the means by which we deliver health care services in this Nation if we are going to achieve long-term cost savings. That is why our organizations continue to support these kinds of demonstration projects that put a focus on service delivery mechanisms that represent meaningful alternatives to the institutions, the hospitals, and the nursing homes.

Senator MOYNIHAN. I happen very much to agree with you. I think you are right and we are going to go through a period for a little bit perhaps, but that doesn't mean we shouldn't be thinking about what ought to be done.

Precisely, I couldn't more agree with you.

Mr. HACKING. I would like to indicate that, on the other side of the coin, our associations can support, and do support, the administration's proposed elimination of the 8½ percent inpatient nursing salary cost differential. Also, we support the proposal to create

authority for civil money penalties for medicare fraud and the proposal to institute competitive contracting for medicare carriers and fiscal intermediaries.

With respect to the the administration's proposed phaseout funding for the health systems agencies, we have to say that we view health planning, certificate of need, and section 1122 review as viable State and local decisionmaking processes with a record of demonstrated success.

The health planning network, as far as we can see, is the only tool presently available on a nationwide basis to control the rate of increase in health care costs.

The planning agencies are currently disapproving about 20 percent of the $5 billion in capital projects they're reviewing each year. We are afraid that without health planning, there is going to be an explosion in capital construction for health care facilities that will mean that the Nation will end up spending a good deal more for these facilities than it will spend with a health planning system in place.

The CHAIRMAN. You are talking about the tax program?

Mr. HACKING. Mr. Chairman, I am talking about the administration's proposed elimination of funding for health systems agencies.

The CHAIRMAN. Oh, I see.

Mr. HACKING. We bring it up before the committee because it is tied in with section 1122 review.

The CHAIRMAN. Well, there is another problem on accelerated depreciation. One problem they have had with the faster writeoff.

Mr. HACKING. Well, we certainly don't want to see more hospital beds in areas where they are not needed.

The CHAIRMAN. I just got out of one of them. [Laughter.]

Senator MOYNIHAN. Mr. Chairman, while you were out a vote—rollcall vote has been called.

The CHAIRMAN. If you can just excuse us for a minute. We want to vote and be right back.

Mr. HACKING. Surely.

[10:28 a.m. to 10:45 a.m. recess.]

Mr. HACKING. Another point I wish to make with respect to the administration's recommendations with regard to the medicare program is that our associations are opposed to the proposed recision and repeal of medicare's coverage of pneumococcal pneumonia vaccine. We think that proposed repeal goes in the wrong direction. We supported medicare's coverage of the vaccine because it puts an emphasis on preventive medicine and, in the process, begins to deemphasize the present emphasis on acute care intervention.

The proposed recision and repeal is shortsighted because ultimately the Medicare program will accrue significant amounts of savings as a result of reduced hospitalization.

Finally, I would like to offer for the committee's consideration two of our own proposals. Since we've opposed some of the things the administration has advanced, we feel it necessary to suggest some cost saving alternatives. Certainly savings need to be effected in order to bring the Federal budget into balance.

We would like to suggest that the committee begin to examine the tax expenditure subsidy that promotes the growth and expansion of hospitals. The tax-exempt status of hospital bonds, which

finances about 50 percent of hospital construction, is going to cost the Federal Treasury about $700 million in lost revenue in fiscal year 1982.

To the extent that this kind of provision is promoting the expansion of hospital construction and additional hospital beds in areas that are now overserved, it goes in the wrong direction, and ought to be sharply curtailed.

We would hope that the committee would review that. We also think——

The CHAIRMAN. I think your time expired sometime ago, so if you could just wrap it up.

Mr. HACKING [continuing]. I have just one more point to make.

We also like to suggest a means for reducing the rate of increase in health costs and especially hospital costs. The Federal Government should provide the States with financial incentives to promote the expansion and development of mandatory rate review programs that we think have been rather successful in holding down the rate of increase in hospital cost at the State level. Success in reducing the rate of increase in hospital costs will also help hold down the rate of increase in Medicare and Medicaid program costs.

Thank you.

The CHAIRMAN. Thank you.

[Statement follows:]

SUMMARY STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

The Associations strongly support federal efforts aimed at reducing the rate of inflation since the elderly population in particular would benefit from such action. In supporting these objectives we also realize (as does the Administration) that it will take some time for anit-inflation policies to be effective. Until they do begin to take effect, however, we will continue to see a decline in the elderly's real income and, specifically, an increase in the rates of poverty and near-poverty among them.

The 1976 poverty data, revealed that the poverty rate for the elderly jumped from 13.9 percent in 1978 to 15.1 percent in 1979 which is the largest rate increase since the Census Bureau began collecting statistics. While the aged poverty rate escalated in 1979, the rate for persons under 65 remained static at 11.1 percent. Furthermore, the rate of near poverty (125 percent of poverty) for the elderly also rose to 24.7 percent as compared to 15.2 percent for the under age 65 population.

Given the deterioration that is occurring in the elderly's income situation, it is unfortunate that programs which serve the elderly—particularly the poor and near poor among them—are being slated for substantial and immediate reductions.

SOCIAL SECURITY

With regard to social security, the Association's are firmly opposed to any attempt to reduce the cost-of-living protection provided by this program which is the cornerstone of the elderly's income security. While the Administration has opposed such action, proposals to cap or otherwise reduce social security COLA's have been surfacing during Congress' deliberations on the Administration's proposed budget reduction package.

As the elderly's participation in the labor force continues at low levels and as the real income derived from their private sources of income falls, the responsibility for an increasing portion of their income support is being shifted to the public programs like social security and Supplemental Security Income which provide some measure of inflation protection. But these public programs do not fully compensate recipients for the inflation losses. Although social security benefits, and those of other public programs, are indexed to the Consumer Price Index, they are not fully protected against inflation for two reasons: first, benefit adjustments occur long after the inflation has had its effect on the purchasing power of the benefits; and second, the standard used in making the adjustments, the CPI itself, we believe may understate the true impact that inflation is having on the budgets of the elderly.

We consider proposals to cap or reduce social security's cost-of-living increases to be the major threat to the elderly's income security. Social security cost of living curtailments will dissipate whatever shred of income security they have left and cause increasing numbers of them to be pushed into the lower reaches of the income distribution and, in many instances, even below the poverty threshold.

Other areas of possible benefit deliberations have been suggested for the purpose of reducing the cost of the social security program. The Administration has suggested eliminating minimum and student benefits even for individuals currently on the benefit rolls. Our Associations would flatly oppose any consideration of benefit deliberalizations in the short term even if these deliberations are imposed only upon new beneficiaries. To produce near-term savings, any benefit cut would have to be imposed immediately with no transitional period—a method of deliberalization we vehemently object to because it would defeat persons' reasonable benefit expectations and allow them no time to adjust their retirement plans accordingly.

With respect to the proposal to eliminate the minimum benefit, the argument is often made that the primary recipients of this benefit are retired federal, state or local retirees who are considered to be reaping a windfall from this benefit. Although many minimum benefit recipients are receiving an unintended advantage from the minimum provision, there would still be many low-income individuals who would be left with no assistance—not even SSI assistance—if the minimum were abruptly eliminated. This group would include early retirees between ages 62 and 65, widows and widowers between ages 60 and 65, and many other low-income, elderly persons who meet the SSI income test, but not the very restrictive assets test.

Reform is needed in the minimum benefit as well as the student benefit area; however, reform should not be achieved by a precipitous cutback of benefits for current and/or newly eligible recipients who have reasonably worked for and planned on this source of income. Time needs to be provided for a gradual, thoughtful and fair phase-out of these benefits as part of a comprehensive restructuring of the social security programs.

MEDICAID

The Administration proposes a cap on Federal expenditures which would reduce outlays by $100 million in the current fiscal year, allow an aggregate increase of only 5 percent in fiscal year 1982, and thereafter limit the increase in Federal matching payments to no more than the rate of inflation. Our Associations oppose this "interim" measure because we believe that strong Federal support of the Medicaid program is an essential component of the "social safety net" for the poor, especially the most vulnerable of this group, the elderly poor. Expenditures for nursing home care constitute the single largest health care liability for persons over the age of 65 and are the major source of catastrophic health expenses for this group—of which over 20 percent will at some point in their lives need to enter a nursing home. In 1979 Medicaid represented a full 49 percent of all spending for nursing home care.

The implications of this "capping" proposal are serious. Current trends toward dual systems of care for Medicaid beneficiaries will intensify, and access to care become even more difficult. Indeed, the $1 billion in savings projected for fiscal year 1982 (with savings exceeding $5 billion by fiscal year 1986) represents a false economy, as the demand for long-term care services is already creating a substantial back-up in our acute-care hospitals. Our Associations believe that the "capping" of the Medicaid program alone without taking effective, across-the-board measures to restrain the uncontrolled escalation of health care costs represents an abrogation of responsibility on the part of the Federal government as the primary purchaser of health care. The course of action recommended by the Administration will seriously impact the availability of quality care for many elderly Medicaid recipients. In light of the dependency of the elderly on the Medicaid program for essential long-term care services and the nonavailability of meaningful alternatives, our Associations oppose this "interim" capping of the Federal portion of Medicaid. Medicare and Medicaid are and should remain complimentary components of any "social safety net" the Congress and the Administration construct beneath needy older Americans.

MEDICARE

There is evidence that the Congress is supportive of an incremental, systematic evolution in the delivery of home health services. In the closing days of the 96th Congress, a number of liberalizations in the Medicare home health program were approved as part of the Omnibus Budget Reconciliation Act of 1980 (P.L. 96–499).

Our Associations, like most of the members of this Committee, strongly supported these changes (such as removal of current 100-visit limits under Parts A and B of Medicare and removal of the 3-day prior hospitalization requirement under Part A). The Administration now proposes to repeal or rescind these "low priority" reforms along with provisions in P.L. 96-611 which provide coverage for pneumococcal pneumonia vaccine under Medicare. To repeal these needed changes in the home health program, costing an estimated $35 million in fiscal year 1982, is not only ill-timed but extremely shortsighted. At the same time our "at risk" population of older Americans with chronic degenerative conditions is mushrooming, our various public and private home health programs are meeting the needs of only some 25 percent of those in need of such long-term care services.

To not allow these reforms to be implemented (effective July 1, 1981) would reflect an inadequate understanding of the dilemma this nation faces in the delivery of long-term care and preventive health services to an aging population.

THE LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

The Associations have serious concerns about folding the LIEAP objectives into an omnibus social service block grant to the States and funding it at substantially reduced levels. Because States would establish their own priorities and exercise total program control over resources, we are concerned that the purpose of this program will be "lost in the shuffle."

Currently the program is funded through the Windfall Profits Tax which in essence redistributes the taxes levied on the high profits oil companies are experiencing due to oil price decontrols to low-income households which can ill afford the skyrocketing costs of home energy. The States do not receive revenue from this tax and may therefore be reluctant to pick up their share of the costs for this assistance. It is important to note that under the current program, 95 percent of the monies are already in the form of block grants to States which drew up their own plans, subject to HHS approval, for dispersing available funds. Currently, Federal guidelines do allow States some flexibility in determining local needs.

Oil price decontrols (and expected gas price decontrols) are Federal initiatives. It is incumbent upon the Federal government, therefore, to continue to provide energy assistance to those in need. We would suggest that it would make more sense for the various energy assistance programs to be consolidated at the Federal level rather than continuing the current fragmented approach of placing some at the State level (through the massive block grant) and keeping other initiatives in various agencies in Washington. Such a coordination of programs would make current benefits more accessible, eliminate duplication or overlap, and fill in the gaps to meet needs where current programs do not. Furthermore, streamlining programs would reduce administrative costs, and within budgetary constraints, make it possible to reach more needy persons.

In our view, this consolidated national energy assistance program would have three major components: direct assistance, weatherization, and outreach. Each State would have the flexibility to determine how best to meet these three goals. Thus the States would have greater flexibility and be better able to consolidate fragmented energy assistance programs within their jurisdiction.

TITLE XX SOCIAL SERVICES

The Administration is seeking new legislation which would consolidate some 40 categorical grant programs (with fiscal year 1981 funding of $9.1 billion) into 4 major block grants. Funding for fiscal year 1982 would be 75 percent of the current (fiscal year 1981) base, or $6.8 billion. Beyond our criticism of the philosophical underpinnings of this proposal, we are particularly concerned about the impact of reduced Federal funding on Title XX Social Services, one of the programs targeted for consolidation, which will represent nearly a third of total outlays for all the targeted programs in fiscal year 1981.

Substantial assistance is provided through the "Core Services" of this program for homemaker/chore and other in-home services that serve to prevent premature and oftentimes unnecessary institutionalization. The State of California, for example, utilizes over a third of all its Title XX funds for this purpose. Also, this program is essential to many older Americans since it provides access (i.e. transportation) to service providers, daycare, counseling, meals-on-wheels, needs assessment, and health related services. In essence, the Title XX program provides the States a highly flexible funding source which enables many elderly individuals to achieve or maintain independent living and economic self-support. A substantial reduction in Federal financial support is likely to force many elderly beneficiaries into higher cost institutional settings.

SUMMARY

In summary, until government indicates it will pursue an effective, multi-pronged, anti-inflation program that includes not just fiscal and monetary restraint but also a tough "incomes" policy that will bring down inflation rapidly and spread the "pain" of curing inflation in an equitable manner, organizations that know what the real economic situation of the elderly is, and that represent their interests, will not be willing to accept proposals that would chip away at the minimal cost-of-living protection and general economic security the elderly have, but otherwise leave double-digit inflation largely unchecked. The proposed cuts in health and human service programs we have described will only serve to further exacerbate the increasingly serious problems the elderly face in coping with inflation and receiving quality health care and other essential human services.

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

ABSTRACT

OVERVIEW OF THE ELDERLY'S INCOME SITUATION

* Largely due to inflation, the poverty rate for the elderly increased substantially from 13.9% in 1978 to 15.1% in 1979, representing the largest increase since the Census Bureau began collecting statistics.
* Inflation is severely eroding the elderly's "real" income received from private sources (such as private pension payments and income from savings) since those sources provide little or no compensation for inflation losses and is making the elderly depend more heavily on public programs (social security and SSI) which do provide a better measure of inflation protection.

SOCIAL SECURITY

* The Associations vehemently oppose capping or otherwise reducing social security's cost-of-living adjustment on the grounds that any cutback in the elderly's inflation protection would further jeopardize their rapidly eroding real income situation.
* We are opposed to funding HI (Part A Medicare) out of general revenues as a response to the short-term financing dilemma of the social security program; instead, we recommend a limited and temporary infusion of general revenues into the cash benefit program during times of adverse economic conditions (high rates of inflation and high unemployment) in order to directly address the cause of short-term imbalances.
* Although we recognize that reform in the minimum and student benefit areas is needed, it should not be accomplished by an immediate elimination of these benefits which would defeat persons' reasonable benefit expectations.
* To ensure the solvency of the longer-term social security system, the Associations recommend a comprehensive restructuring of the social security benefit and financing structures which would encourage employment of older workers and sort out its social adequacy functions from its earnings replacement (pension) function.

HEALTH PROGRAMS

* The Associations oppose the proposed Medicaid "cap", as the projected savings represent a false economy -- leading to increased hospital back-up, increased Medicare costs, and a serious impact on quality of care. Without effective, across-the-board measures to restrain the uncontrolled escalation of health care costs, the elderly will continue to bear a disproportionate burden as a result of health care cost inflation due to their relatively inflexible consumption patterns. The Medicaid program is an essential part of the "social safety net" the Congress has constructed beneath the truly needy elderly.
* Significant increases in cost sharing liability on the part of Medicare beneficiaries should be avoided since the health care cost spiral continues to push the total cost of health care for older Americans well beyond their growth in income and increasingly into poverty and near-poverty status. Besides being cost promoting in the long run, such efforts to reduce utilization of services inadequately recognize the rising portion of total health care costs that are paid out-of-pocket by older Americans.

continued

* In light of the fact that the revenue losses from tax expenditures continue to exceed the annual rate of increase in direct Federal outlays, our Associations urge this Committee to seriously consider (in tandem with budget cuts in these programs) such items as the tax-exempt status of hospital bonds and the exclusion from taxable income of employer-paid health insurance premiums which together will cost the Federal government in FY1982 over $29 billion in direct revenue losses.

THE LOW INCOME ENERGY ASSISTANCE PROGRAM

* The Associations have grave concerns about the Administration's proposal to consolidate LIEAP and AFDC emergency assistance into a block grant which would be funded at 25% below current levels. With energy prices continuing to skyrocket, low income elderly can ill afford to be "lost in the shuffle" of a program which would allow states almost total flexibility in dispersing the monies.

ANTI-INFLATION STRATEGY MUST BE COMPREHENSIVE AND MULTI-FACETED

* Controlling inflation is the first priority of older Americans. While the Associations recognize that spending restraint is one part of the strategy necessary to curb inflation, a comprehensive and multi-faceted anti-inflation strategy must be employed which also includes: a strong incomes policy; control of money supply growth; and promotion of competition in the economy using regulation or deregulation as appropriate.

I. INTRODUCTION

Our Associations are pleased to present our views on the budget cuts affecting our nation's elderly that the Administration has proposed in their Program for Economic Recovery. Our Associations strongly support the Administration's promised efforts to combat inflation, revitalize the economy, and balance the federal budget. Regarding the federal budget, we continue to advocate that it be balanced over the business cycle. However, we have reservations as to how the Administration proposes to achieve this balance. Specifically, we would contend that sudden and drastic reductions in federal support for certain income, health and human service programs would leave gaping holes in the "social safety net" that the Administration contends it has created for the truly needy, dependent and vulnerable among our elderly population.

In keeping with the purpose of this hearing, we would like to comment on those budget cuts that disturb us most, the reasons for this concern, and the consequences of such reductions. In addition, we will provide you with a number of alternative recommendations for reducing federal spending in these areas.

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II. OVERVIEW OF THE ELDERLY'S INCOME SITUATION

A. Income Gains Made in the Past are Being Eroded

Rapid growth and expansion of government income support programs during the late 1960's and early 1970's caused the elderly's average income to rise over the past decade in real terms and in relative terms (relative to the income of the younger population). This trend was confirmed by a 1980 study entitled "Inflation and the Elderly", which was prepared for NRTA-AARP by Data Resources, Inc. (DRI).

According to the DRI study, average elderly income (in aggregate terms) managed to keep pace with, and slightly exceed, the inflation rate from the late 1960's into the late 1970's. Taking into account the incomes of elderly persons newly retiring during this period, as well as elderly persons already retired, aggregate elderly incomes rose at an average annual rate of 7.7% versus an annual CPI rate of 6.1% over the period of 1967 through 1976. As a result, the average incomes of those over age 65 increased from about 48% of the average incomes of the non-elderly in 1965, to about 55% by the end of the 1970's -- just about where the elderly's average incomes had been in the mid-1950's.

A recent study, authored by Bridges & Packard of the Social Security Administration (published in the January 1981 _Social Security Bulletin_), refines this analysis by examining what has happened to the average incomes of one cohort or class of families headed by elderly persons over the 1970-77 period. It was found that despite the large social security benefit increases that were provided in the early 1970's, average real incomes of this cohort of families fell by 4%. This occurred for two reasons: first, the earnings component of their income dropped significantly as their advancing age decreased their labor force participation; and second, their private sources of income (namely, private pensions, savings and assets) declined in value since these private sources have little or no inflation protection.

The incidence of poverty among the aged steadily declined from the late 1960's, when one quarter of them lived in poverty, through to 1978 when the rate had declined to 13.9%. Despite this substantial progress in reducing poverty, there is mounting evidence that inflation has begun (and will continue) to wipe away that progress. After this decline in aged poverty rates, the rate increased substantially from 13.9% in 1978 to 15.1% in 1979, representing the largest increase since the Census Bureau began collecting statistics. Again we believe the fixed nature of many of the elderly's income components contributed to this poverty increase.

The 1979 poverty data also revealed the degree to which the elderly, relative to other population groups, are vulnerable to the effects of inflation. While the aged's poverty rate escalated, the rate for persons under age 65 remained static at 11.1%. Additionally, elderly near-poverty rates (defined as the percentage of households having incomes within 125% of the poverty threshold) rose and are disproportionately high; in 1979, 24.7% of the elderly were concentrated in this income category, compared with 15.2% of the under 65 population.

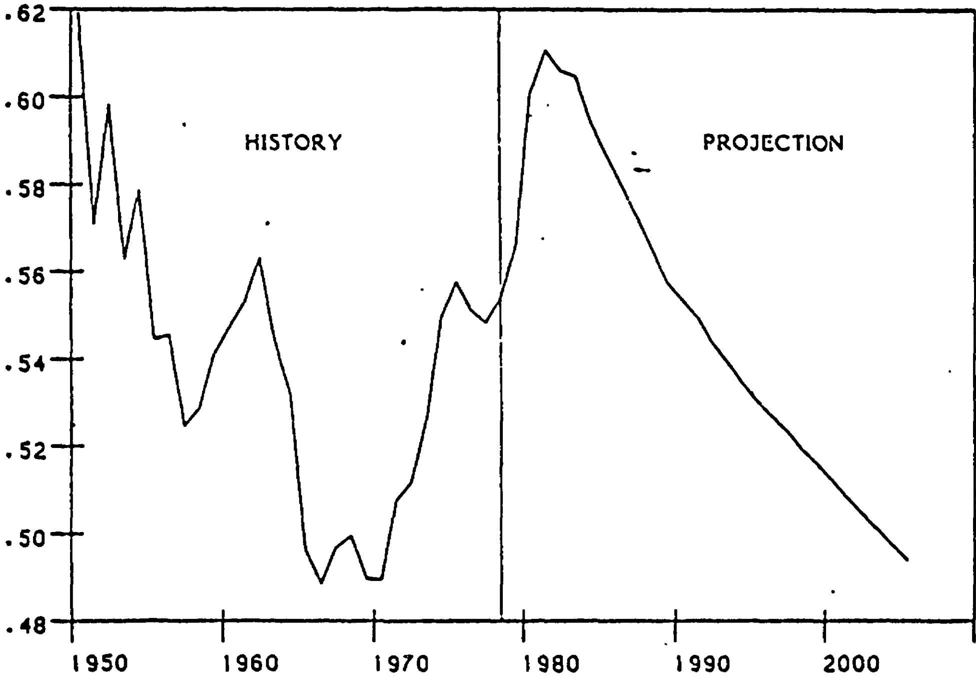
Despite the limited progress that the elderly achieved in terms of income during the last half of the 1960's and during the 1970's, other statistics demonstrate how economically disadvantaged the elderly continue to be relative to the rest of the population. In 1979, while only 9% of nonelderly-headed households had annual incomes below $5,000, and only 21% of them had incomes under $10,000, 31% of elderly-headed households found themselves in the former category while 62% were included in the latter. Even adding the cash-value of the in-kind benefits the elderly receive to their income levels cannot change the fact that the elderly, as a group, generally subsist on low and, in many cases, extremely inadequate incomes.

B. Future Prospects Poor

As for the future, the income situation for the elderly appears bleak. In the study previously cited, Data Resources, Inc. (DRI) forecast that even if current government programs remain in place with no legislated cutbacks, the elderly's share of income relative to that of the nonelderly will decline sharply beginning in 1981. This decline is illustrated by the figure on the next page. While the reasons for this decline are complex, the major factor remains the continuing high rate of inflation.

Although, in the past, much progress was made in reducing poverty and improving the income status of the aged, these recent statistics and forecasts indicate that the elderly are most vulnerable to inflation, that they are sustaining disproportionately larger losses as a result of it, and that a rapid erosion of progress made in the past has already begun. In short, continued high rate inflation could reduce the elderly to an economic situation worse than that which prevailed a decade ago when nearly one-fourth of them were poor.

AVERAGE INCOME OF THOSE OVER AGE 65
RELATIVE TO THOSE UNDER 65



Source: "The Aged & the Future Economy: An Interactive Analysis", Data Resources, Inc., November 1980, page 19.

C. Inflation and the Elderly's Income Components

Inflation is significantly altering the balance and relative importance of the various components of the elderly's income. Public programs are bearing an increasing portion of the income support responsibility as inflation constricts the "real" income received from private sources (such as private pension payments, income from savings, etc.) since those sources provide little or no compensation for inflation losses.

Private pensions, for example, are generally not indexed. A Bankers Trust study of private pension plans cited an average benefit increase of 16% in the period 1969-79, compared to a CPI increase of 47%. A 1970 retiree with a non-indexed private pension is now receiving a real income from that source of less than one half the 1970 value.

With respect to savings, not only has the rate of interest income not kept pace with the rate of inflation (largely because interest rates have been limited to 5-6% by Regulation Q), but the real value of savings accounts has also been eroding rapidly. According to DRI's calculations, $1,000 invested in a savings account in 1967 would have been reduced to $667 in 1978 if the saver decided to divide the interest between current income and reinvestment. These losses are common to most of the aged and are disproportionately borne by the low-to-middle income elderly (as this is often their only form of financial savings). It

is estimated by Professor Kane of Ohio State University that Regulation Q has cost older consumers almost $20 billion over the past ten years.

Those elderly who invested in stocks and bonds to produce retirement income have sustained not only real capital losses over the past decade but also low rates of return on investment. Because stock prices (as measured by Standard & Poors) have not risen over the past ten years, inflation has cut the real value of the equity in most stocks in half. Dividends, which are taxable, have averaged 4% over the ten-year period, compared to an average 6-7% rise in the CPI.

A typical pattern for many elderly households is to save for retirement, and at retirement, convert their savings to "secure" forms (such as money in the bank, or corporate bonds), sell their homes to clear themselves of any mortgage debt and to gain additional liquid resources, and then rent. A retiree of ten years ago, following this pattern, would have been impacted quite severely by the recent inflation since the real value of their retirement savings would have likely been cut in half.

As the elderly's participation in the labor force declines and as the real income derived from their private sources of income falls, the responsibility for an increasing portion of their income support is being shifted to the public programs like social security and Supplemental Security Income

which provide some measure of inflation protection. Table I (shown below) demonstrates this trend.

TABLE I

INCOME SHARES BY SOURCE

	1967	1977
Age 55-61		
Wages and Salaries	76.6	70.9
Social Security	1.6	3.1
Asset Income	5.2	7.6
All other	16.6	18.4
Age 62-64		
Wages and Salaries	67.3	50.0
Social Security	7.6	15.3
Asset Income	7.9	11.3
All other	17.2	23.4
Age 65-71		
Wages and Salaries	34.3	20.9
Social Security	27.6	38.0
Asset Income	14.2	17.0
All other	23.9	24.9
Age 72 & over		
Wages and Salaries	10.9	5.7
Social Security	43.0	48.3
Asset Income	19.5	22.9
All other	26.6	23.1

Source: Inflation and the Elderly - Part II, report prepared by Data Resources, Inc. for NRTA-AARP, January, 1980.

In 1976, it was estimated by the Social Security Administration that two-thirds of the elderly depended on social security for at least one-half of their income and for 28% of the aged, social security amounted to 90% or more of their total income. In 1976, 11% of

persons age 65 and over reported public assistance as an income source; 32% said such assistance represented one-half of their total income and 22% said it represented 90% or more of their income.

Given the deterioration that is occurring in the elderly's income situation even with increased reliance on government programs, it is unconscionable that programs which serve this vulnerable segment of our population are being slated for substantial and immediate reductions.

III. SOCIAL SECURITY

A. Social Security: Cornerstone of the Elderly's Income

A 1977 Congressional Budget Office (CBO) study isolated the impact of various government programs on the incidence of elderly poverty. The study showed that, were it not for income from social insurance programs, 59.9% of all families headed by an elderly person would have fallen below the subsistence-based poverty line in fiscal 1976. Social insurance programs, primarily social security and including federal pensions, substantially reduced that elderly poverty rate from 59.9% to 21%. Cash assistance programs, such as Supplemental Security Income (SSI) and veterans' pensions, reduced the rate even further to 14.1%. Of significance is the finding that social insurance programs, dominated by social security, were responsible for lifting an overwhelming 70% of the elderly out of poverty.

The social security system obviously represents the cornerstone of the elderly's income. Given its significance, improvements in social security's benefit and financing structures must be considered in order to insure its short and long term financial viability as well as insure that it will be able to continue to serve the present generation of older Americans and accommodate what will be the different needs of the future elderly population.

B. Causes of Short-Term Problem: Adverse Economic Conditions

Over the past eight years, the financial well-being of the system has proven to be extremely vulnerable to the effects of high inflation, high unemployment, and declines in the rate of productivity growth and real wage growth. Inflation has consistently been much higher than expected and we have experienced periods of practically negligible growth or actual decline in real wages. According to Social Security Administration, calculations (using average social-security-covered wages and salaries), in 1979, prices rose faster than wages, yielding a -2.1 real wage differential; in 1980, the differential was -4.6; and in 1981, it is projected to be -2.2. Because of declining real wages, revenue for the system has not increased sufficiently to cover the cost of inflation-induced increases in social security expenditures.

High rates of unemployment for extended periods have also severely reduced tax revenue to the system. At the same time, high unemployment can cause increased costs for the system because it causes workers--particularly older, unemployed workers--to be attracted into retirement or disability status.

It is these trends that are largely responsible for the unraveling of the 1977 financing package in spite of the large payroll tax increases scheduled by that legislation. Congress should recognize that the current payroll tax mechanism can no

longer be relied upon to meet fully and consistently the short-term financial needs of social security. In addition, we have come to realize that over-reliance on the payroll tax structure to fund the massive social security system has, in and of itself, become a contributing factor to our economic problems, especially inflation. The Congressional Budget office estimated last this year that the 1981 payroll tax increase would increase the CPI by 0.2% in 1981 and increase unemployment 0.2% by 1983.

C. Associations' Recommendation: Limited and Temporary Use of General Revenues

Violently fluctuating economic conditions produce a great deal of uncertainty for the social security system and make sound financial planning utilizing the payroll tax extremely difficult, if not impossible. Given the current economic climate, some flexibility to use alternative revenue sources should be built into the system. For this reason, our Associations recommend use of two counter-cyclical general revenue devices specifically designed to offset some of the financial impact that high rates of inflation, low rates of productivity and economic growth, and high unemployment have on the program. For over five years we have espoused these types of economic safety nets for the system and we are convinced that only through use of such devices can we ever expect the system to be permanently rid of short-term imbalances caused by unforeseen adverse economic conditions.

Specifically, we propose that federal general revenues be used to defray partially the cost of automatic benefit increases when these increases exceed a certain percent per year--perhaps 6% or 8% could be selected as a realistic trigger figure.

To complement this proposal, our Associations also recommend use of another counter-cyclical general revenue financing device to replace payroll taxes lost to the system as a result of unemployment rates in excess of six percent. This device would act as another automatic stabilizer -- this time on the revenue/income side of social security -- and would assist Congress in predicting future payroll tax needs of the system by curtailing another area of uncertainty. However, this device cannot stand alone as the only counter-cyclical device. It is not likely to produce sufficient revenue to avert the short-term imbalance the system faces, because high rates of inflation combined with low real wage growth are more likely to be the conditions which will more severely damage the system's financial structure in the near term.

To those who have been adamantly opposed to use of general revenue financing for the system out of concern that this could lead to unrestricted benefit expansions, we would point out that our proposed mechanism is designed solely to compensate the system for adverse economic conditions and would be trig-

gered only by such events. Once adverse economic conditions subside, this mechanism would automatically be phased-out. Since it is clear that an infusion of additional revenue is needed to stabilize the cash benefit programs, the mechanism we are recommending is one of the most conservative and restricted in design.

We do not wish to leave this topic without some comment on the source of the general revenues which we propose to use for social security purposes. In our view, these general revenues can come from: (1) increased and non-earmarked revenue derived from existing or new taxes; (2) increased revenue flowing from inflation throwing individuals and corporations into higher tax brackets; (3) deficit financing during periods of recession; (4) the shifting of expenditure priorities within the context of the federal budget process; and (5) the fiscal dividend that real economic growth will yield when it resumes.

To the extent that general revenues are needed in any year, the choice of source(s) for those funds should be made through the Congressional budget process in the light of the needs of the economy at that time. We hasten to add that since our Associations want the federal budget brought into balance when the economy emerges from the recession and that balance maintained over the business cycle, in coming years, no single source for the general revenues needed should be relied upon year after year.

D. Alternative Short-Term Proposals

1. General Revenue Financing of Part A Medicare

Several public policy experts and advisory bodies (including the 1979 Advisory Council) have recommended either partial or full financing of the HI Program out of general revenues (with an accompanying shift of part of the HI tax rate to OASDI).

NRTA-AARP believe it is inappropriate to consider funding HI out of general revenues as a response to the short-term financing dilemma. This proposal would make a major change in the social security system and therefore necessitates more careful deliberation and future planning. General revenue financing for HI should be considered on its own merits--not for the amount of short-term revenue it would generate for the cash benefit programs. We hope Congress will not seize upon the proposal solely to avert a short-term crisis in the cash benefit programs or to roll back part or all of the 1981 payroll tax increase.

The first drawback of the proposal relates to its cost. Financing half of the HI out of general revenues would necessitate a large ($14 billion) expansion of the federal budget and this amount can be expected to grow rapidly in future years since uncontrolled hospital costs will continue to rise in excess of the overall inflation rate.

More importantly, however, shifting payroll taxes from HI to OASDI does not respond to the specific cause of the short-term problem and therefore would not really provide the kind of automatic protection for the cash benefit programs that they need; it merely provides more payroll taxes in the short-term with absolutely no assurance that future economic downturns will not again upset its financial balance. Over the longer-term, the general revenue for HI proposal may end up doing more harm than good. Severing the payroll tax contribution/entitlement concept of the program, coupled with the large, on-budget costs of this proposal, could invite a means-test of program benefits as well as preclude enactment of some long needed reforms in Medicare.

We acknowledge the argument that it is more appropriate to put general revenues into the HI portion of social security than the cash benefit programs because HI benefits are unrelated to contributions and life expectancy. The cash benefit programs are thus said to be "actuarial" and therefore suited for payroll tax financing.

There are problems with this line of argument. HI payroll tax payments are supposed to be analogous to insurance premium payments to establish eligibility for benefits. If this is eliminated, then something else--a means test perhaps--may end up being used for determining eligibility. Furthermore, the size of OASDI benefits is not strictly and solely related to earnings records and life expectancy; the number of dependents a worker has is also an important determinant.

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2. Capping or Reducing Cost-of-Living Increases

In reaction to the historically large automatic social security benefit increase in 1980, several proposals have surfaced that would reduce the size of the cost-of-living adjustments provided by the social security program. These proposals have taken several forms: (1) capping the increase at 70% or 80 % of what would otherwise be the full adjustment; (2) altering the construction of the Consumer Price Index (CPI) in a way that would yield a lower increase; and (3) using either a price or a wage index, whichever yields the lower benefit increase. These proposals have been considered quite attractive since, of all the possible benefits cuts, reducing the social security cost-of-living protection would produce relatively large and immediate savings for the program and for the federal budget.

NRTA-AARP urge Congress to reject these proposals on the grounds that any cutback in the elderly's inflation protection would further jeopardize their rapidly eroding real income situation. It should be clear from the above discussion that because they are a low-income group, the elderly represent one segment of society that should not be singled out for any curtailment in the only inflation protection which government provides them.

The inflation trend, by rapidly dissipating the real value of many of the elderly's fixed income components, is driving increasing numbers of them into the lower reaches of the income distribution.

Even the social security cost-of-living increases which the elderly receive do not maintain benefit purchasing power because these increases are provided long after rising prices affect recipients' budgets, and they are measured by the general CPI. With respect to the first point, a January 1981 OMB study (entitled Report on Indexing Federal Programs) indicates that, since 1975, social security recipients have experienced a 3.4% decline in real benefit levels due solely to the lengthy lag time in adjusting benefits and the accelerating inflation rate.

Although it has been argued that the current CPI, at times, overstates the inflation rate for the general public, most detailed studies of this issue show that the experience has been the opposite for the elderly. A study prepared for us by Data Resources, Inc. (DRI) on the elderly's expenditure patterns indicates that the general CPI tends to understate inflation's impact on elderly budgets. This occurs because the elderly, as compared to younger consumers, spend more of their income in three categories of expenditures which are experiencing the most rapid price inflation--food at home, fuel and

utilities, and out-of-pocket medical expenses. Because the general CPI is not specifically weighted to reflect the elderly's expenditure patterns, it has distorted and understated the true impact of inflation on their budget.

Statistics from the DRI Study indicate that, since 1970, the cost of living for the elderly has risen faster than the cost of living for younger consumers. Between 1970 and 1979, the Bureau of Labor Statistics all-urban CPI rose an average 7.2% rate compared to 8.3% for food at home, 9.4% for fuel and utilities, and 7.9% for medical care. These costs have risen at a composite rate of 8.4% per year versus a CPI increase since 1970 of 7.2% per year. The DRI Study further indicates that the adverse effects of this high inflation rate among the core necessities are greater for the poorest and the oldest of the elderly who, because of their lower incomes, have less flexibility in altering their spending patterns in response to higher prices.

Since higher inflation in the core necessities is expected to continue in the 1980's, the CPI's understatement of inflation's impact on elderly budgets will continue as well. For 1979 through 1985, DRI has forecast an 8.7% rise in food at home, 9.9% for fuel and 10.1% for health care, compared to an 8.7% rise in the overall CPI.

The Bridges & Packard study (previously cited) found that, over the 1967-79 period, an index, specially constructed for older consumers (CPI-O) to reflect more accurately their expenditure patterns, grew slightly faster than the economy-wide or general CPI-W. Their findings are consistent with the findings of other recent studies on this subject. The following table reflects their research.

Table 1.—Constructed consumer price indexes: Annual indexes and percentage changes, 1967-79
[1967 = 100.0]

Year	CPI-O		CPI-W$_c$	
	Index	Percentage change	Index	Percentage change
1967	100.0	...	100.0	...
1968	104.2	4.2	104.2	4.2
1969	109.0	4.5	109.9	5.5
1970	116.5	6.0	116.2	5.7
1971	121.7	4.5	121.2	4.3
1972	125.7	3.3	125.1	3.2
1973	133.1	5.9	132.3	5.8
1974	147.9	11.1	147.0	11.1
1975	162.0	9.5	160.7	9.3
1976	172.0	6.2	170.6	6.2
1977	183.5	6.7	181.7	6.5
1978	197.6	7.7	195.2	7.4
1979	219.9	11.3	217.7	11.5

(Source: Bridges, Benjamin and Packard, Michael D., "Price and Income Changes for the Elderly", Social Security Bulletin, January 1981, page 4.)

Bridges & Packard, however, acknowledged the inherent weakness of their specially constructed CPI-O. In constructing this index, the authors merely reweighted the seven major expenditure categories of the general CPI to reflect the elderly's different expenditure patterns in these seven aggregate categories. In order to produce a more accurate and valid older persons index, these seven expenditure categories must be pulled apart -- or disaggregated -- into more expenditure classes and then reweighted to

resemble the elderly's spending patterns. At the present time, an economist, Dr. Thomas C. Borzilleri, is conducting this type of research for our Associations. We would be pleased to share with the Committee the results of his research when they are available in the near future.

3. Comments on Proposals that Would Alter Current Indexing

Our Associations urge Congress to reject proposals that would alter the construction of the CPI solely for the purpose of moderating the rate of increase it registers. The public would quickly perceive this as either an underhanded attempt to curtail the growth of indexed entitlement programs or an attempt to lower fictitiously the inflation rate.

Some have endorsed the use of the CPI-X-1, recently developed by BLS, because it would remove the current CPI's flaw related to the treatment of homeownership. We agree that the current CPI tends to overstate increases in housing costs. From the point of view of the elderly, however, for every overstatement in the general CPI, there is probably at least one understatement in another expenditure category.

The current CPI must be more closely examined than it has been to date. If Congress wishes to change the CPI used to index the entitlement programs benefiting the elderly, then it ought to develop an index which will accurately reflect their expenditure patterns.

Another prominent proposal to alter indexing would limit cost-of-living increases (especially those provided by the social security program) to either the average rise in wages or the average rise in prices, whichever is lower. This "wage cap" would result in a severe downward ratcheting of real benefit levels particularly if imposed over a number of years. For instance, the CBO has estimated that this proposal would reduce social security benefits alone by $26 billion over the 1981-86 period.

Some proponents of the wage cap proposal seem to be advocating it on the grounds of equity -- in other words, it is inequitable to allow the incomes of retirees to rise more rapidly than the incomes or wages of workers who must support government programs through taxes.

Unless Congress is willing to adjust benefits according to the rise in wages <u>on a permanent basis</u> even when wages begin to outpace prices in the future, then the wage indexing cannot be sold on the grounds of equity. Beneficiaries will feel -- and rightfully so -- that they will always be getting the "short end of the stick." The overall rationale for cost-of-living adjustment mechanisms must be consistent. These mechanisms are <u>not</u> for the purpose of passing along to current retirees increases or decreases in the standards of living of current workers, but rather for the purpose of maintaining benefit purchasing power.

In several years over the past decade, prices have increased at a faster pace than wages. This trend, however, is projected by most economists to reverse itself within the next two years. Workers can have reasonable expectations over their future working lives of making up any real income loss they are currently suffering as a result of low growth, the recession and high inflation. Retirees, because they are not wage-earners and have many fixed components to their income, have no expectations for recouping the inflation losses they have already incurred and will continue to incur as long as inflation is with us.

The elderly's real income situation and their standards of living are declining. Poverty rates among them are rapidly escalating. All this deterioration is occuring despite the provision of relatively "full" cost-of-living increases by the major income support programs. If these increases are curtailed in any manner (especially in a relatively permanent manner through use of a wage cap or CPI-X-1, which would curb benefit growth into the future), then the nation's elderly could easily be reduced to the economic level that prevailed a decade ago, when one out of every four of them were below the poverty level.

4. Other Potential Benefit Cuts

Other areas of possible benefit deliberalizations have been suggested for the purpose of freeing up or generating revenue in the short term. The Administration has suggested eliminating minimum and student benefits even for individuals currently on the benefit roll. Our Associations would flatly oppose any consideration of benefit deliberalizations in the short term even if these deliberalizations are imposed only upon new retirees. To produce near-term savings, any benefit cut would have to be imposed immediately with no transitional period -- a method of deliberalization we vehemently object to because it would defeat persons' reasonable benefit expectations and allow them no time to adjust their retirement plans accordingly.

We would add that some of these benefit reforms have some merit. However, these are major changes that should be phased-in over a long period of time and considered only in the context of long-term, comprehensive restructuring of the entire income support structure, not with a view toward improving the short-run financial status of the system.

With respect to the proposal to eliminate the minimum benefit, the argument is often made that the primary recipients of this benefit are retired federal, state or local retirees who are considered to be reaping a windfall from this benefit. This argument is made based on a 1979 survey of minimum beneficiaries done by the GAO. This survey is

far from comprehensive, since no information (regarding degree of income dependence on the minimum benefit) was obtained from 26% of those surveyed.

Although many minimum benefit recipients are receiving an unintended advantage from the minimum provision, there would still be many, low-income individuals who would be left with no assistance--not even SSI assistance--if the minimum were abruptly eliminated. This group would include early retirees between ages 62 and 65, widows and widowers between ages 60 and 65, and many other low-income, elderly persons who meet the SSI income test, but not the very restrictive assets test. Even the GAO Report recognized the potential hardship to this group of recipients and recommended the following:

> "To minimize the hardship of the few needy beneficiaries who would not be eligible for SSI, the Congress could authorize a limited SSI payment which would replace a portion of the social security benefit lost when the minimum provision is eliminated."

Reform is needed in the minimum benefit as well as the student benefit area, however, reform should not be achieved by a precipitous cutback of benefits for current and/or newly eligible recipients who have reasonably worked for and planned on this source of income. Time needs to be provided for a gradual, thoughtful and fair phase-out of these benefits.

The Administration has also proposed to tighten up the disability insurance program by improving its administration, providing a stricter recency-of-work test and imposing a "megacap" which would limit total disability benefits so that they would not exceed a worker's prior after-tax earned income.

While we support more uniform administration of the DI program to reduce the error rate (with the increase in personnel necessary to carry this objective out), we oppose the reduction in the recency-of-work test and the megacap. Tightening the recency-of-work test may deny benefits to persons who gradually become disabled and unable to work. The "megacap" drastically changes the entitlement concept of the DI Program because it would introduce a "means test" into the program. Also, it should be noted that Congress already moved last year to tighten up the DI program. Further cuts are unjustified and would be overly severe in their impact on this group of persons.

E. Fundamental Reform of Social Security Benefit and Financing Structures Needed

The convergence of demographic, employment and economic trends will make it impossible to continue the system as presently structured into the next century. If perpetuation of social security in such a form is attempted, either a massive payroll tax increase (a near doubling of current rates)

or benefit cuts of equal magnitude (through such steps as raising the retirement age and/or price indexing of the benefit formula) will be necessary. Any large payroll tax increase would be incredibly disruptive not only to our economy but also to our political and social fabric. And, if benefits are substantially cut, the elderly will inevitably be forced to sustain a significant deterioration in their living standards and perhaps face the high poverty rates that prevailed in the 1950's and 1960's.

To avoid the unhappy choice between large payroll tax increases and a piecemeal dismantling of the system's benefit protections, we recommend comprehensive reform of the system's benefit and financing structures. This reform must respond to the trends cited above, particularly the adverse economic trends consisting of a high, hard-core inflation rate, low real economic growth and sluggish productivity gains. These economic trends are financially detrimental to the system because they greatly restrict the resources available to finance social security and, at the same time, certain features of the system (particularly its over-reliance on payroll taxes) exacerbate rather than help alleviate many of these economic problems. This situation dictates that we begin now to rationalize the social security financing and benefit structures to insure that scarce resources

are not wasted and that the financing mechanism used contributes to, rather than detracts from, our future economic health.

Briefly, to achieve these objectives, we suggest that the revamped social security system include the following:

* a benefit structure that would strongly encourage employment on the part of both younger and older workers;

* a more diverse and less inflationary financing structure that would use separate and appropriate tax mechanisms to finance social security's divergent functions of earnings replacement and social adequacy;

* a benefit structure that is equitable in its treatment of individual workers (particularly working wives and single individuals); and

* a benefit structure which provides benefits in a cost-effective and target-effecient manner and which does not overlap or duplicate the benefits provided by other government income support programs.

The details of our Associations' comprehensive long-term restructuring plan for the social security system goes beyond the scope of this hearing. We would be pleased to provide you with a detailed statement on our position upon request.

IV. HEALTH PROGRAMS

The Administration's budget cuts in health programs are based upon the contention that Federal and State regulatory efforts have failed to contain the rising tide of health care costs due to the underlying cost-promoting bias in the financing of services. Therefore, a number of interim measures have been proposed by the Administration prior to the adoption of comprehensive legislation to remedy market distortions and encourage competition in the delivery of health care. Our Associations believe that the elimination of certain programs and the devastation of others through reduced federal support is at best shortsighted. We believe, as many of the members of this Committee must, that the transformation of the health care marketplace contemplated by the Administration is not possible in such a short time frame. While developing meaningful (price) competition in this market is indeed a desirable goal, we hardly think it justifies the extreme interim spending reductions proposed by the Administration in certain programs.

A. Medicaid

The new Administration states that the Medicaid program contains excessive benefit provisions, overly generous eligibility criteria, and is poorly mangaged - all leading to excessive cost increases. The complaint is expressed as to the

15% a year growth in total Medicaid spending over the past 5 years (as hospital costs continue to escalate at annual rates of 16-18%). As an interim measure, therefore, the Administration proposes a cap on Federal expenditures which would reduce outlays by $100 million in the current fiscal year, allow an aggregate increase of only 5% in FY 1982, and thereafter limit the increase in Federal matching payments to no more than the rate of inflation (measured by the GNP price deflator). The Administration contends that this can be done "without reducing basic services for the most needy" -- though there is some question as to how or by whom "basic services" and the "needy" would be defined. Furthermore, during the 1983-86 period the Administration expects to institute comprehensive health financing and Medicaid reforms, as yet unspecified, to reduce the rate of health care cost inflation and to improve Medicaid.

Our Associations oppose this "interim" measure because we believe that strong Federal support of the Medicaid program is an essential component of the "social safety net" for the poor, especially the most vulnerable of this group, the elderly poor. Approximately one in five older Americans are Medicaid recipients. Currently, 41% of total Medicaid expenditures are going to nursing home care. Expenditures for nursing home care constitute the single largest health care liability for persons over the age of 65 and are the major source of catastrophic health expenses for this

group - of which over 20% will at some point in their lives need to enter a nursing home. The importance of the Medicaid program to the elderly is further highlighted by the fact that 87% of all public expenditures for nursing home care ($8.8 billion) and 49% of all spending for nursing home care in 1979 were Medicaid dollars.

The Administration's proposal is expected to reduce the total federal payment to State Medicaid programs' in FY 1981 by $300 million and in FY 1982 federal spending would be reduced from $18.2 billion to $17.3 billion as a 5% cap is implemented, resulting in all but three States receiving reduced (federal) payments. The implications of such action are serious. Current trends toward dual systems of care for Medicaid beneficiaries will intensify and access to care become even more difficult. Indeed, the $900 million in savings projected for FY 1982 (with savings exceeding $5 billion by FY 1986) represents a false economy, as the demand for long-term care services is already creating a substantial back-up in our acute-care hospitals. The impact of this "capping" proposal on the Medicare program, therefore, deserves immediate action.

Our Associations believe that the "capping" of the Medicaid program alone without taking effective, across-the-board measures to restrain the uncontrolled escalation of health care costs represents an abrogation of responsibility on the part of the Federal government as the primary purchaser of

health care services. In this instance, taking the expedient course of action recommended by the Administration will seriously impact the availability of quality care for many elderly Medicaid recipients, the most vulnerable and dependent of all groups. This seems to be in stark contrast to the avowed purposes of the Administration's budget proposals and at variance with his repeated pledge to protect those truly needy individuals dependent on Federal assistance.

Our Associations believe that the Administration's Medicaid "capping" proposal deserves serious and thoughtful consideration and that all alternative proposals should be carefully evaluated. This is not to say that we do not share the Administration's view that the entire Federal mandating process should be reviewed. The States clearly should maintain and perhaps even be allowed to expand their authority to restructure Medicaid benefits to most appropriately meet local needs. However, in light of the dependency of the elderly on the Medicaid program for essential long-term care services and the nonavailability of meaningful alternatives, our Associations oppose the capricious reduction of Federal support for the Medicaid program and urge you to reject this portion of the Administration's budget package.

The Congress has expressed a desire to see that cost effective alternatives and options to nursing home care are developed (most recently in the Medicare home health

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care liberalizations of P.L. 96-499, the Omnibus Budget Reconciliation Act of 1980). Yet placing an "interim cap" on the Federal matching payment to already severely strapped State Medicaid programs would only cause further restrictions to be placed on the availability of mandatory home health services and (optional) community-based personal care services.[1/] Currently, access to home health care is at best difficult in those many States where reimbursement levels are far below even the Medicare rates. Instead of moving to dismantle the semblance of a fully integrated national health care program for the poor, the Administration and Congress should be working (through appropriate incentives) to obtain State-to-State uniformity in the range and scope of benefits that are available- with obvious concerns as to the availability and need for particular service mixtures.

Additional and significant reductions in Federal support for the Medicaid program as proposed by the Administration will have a serious impact on the availability of quality health care services, particularly institutional long-term care services. State Medicaid rates for nursing home care are clearly inadequate in most cases and Medicaid patients are often only maintained because facilities' private pay patients subsidize their care. Further reductions in Federal support will undoubtedly make what is at present a bad situaation worse.

1/ Only 4 States offer personal care services to their categorically needy under Medicaid while 10 provide such benefits to this group and the medically needy as well.

In addition, in light of the severe reductions that are scheduled in Federal matching payments for the Medicaid program and the untenable situation many States face in funding this joint Federal-State program, eliminating the 50% Federal minimum matching rate, as proposed by the Finance Committee staff, would be unnecessarily extreme and have a serious impact on those elderly so dependent on the Medicaid program (i.e. the poor, frail elderly in nursing homes). We are also curious as to the rationale behind requiring a "nominal" copayment (only) for patient initiated services. We would remind the Congress that Medicaid covers only approximately one-third of those individuals below the poverty level and that the median income of Medicaid households is $5,990. Frankly, we do not believe even "nominal" copayments on mandatory or optional services are justified under these circumstances.

B. <u>Medicare</u>

There is evidence that the Congress is supportive of an incremental, systematic evolution in the delivery of home health services. In the closing days of the 96th Congress, a number of liberalizations in the Medicare home health program were approved as part of the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499). Our Associations, like most of the members of this

Committee, strongly supported these changes, which included (Section 930): the removal of current 100-visit limits under Parts A and B of Medicare; removal of the 3-day prior hospitalization requirement under Part A; the inclusion of occupational therapy as a qualifying ("skilled") service; the nonapplicability of the Part B deductible for home health services; the elimination of discriminatory licensing requirements based on the tax status of a home health agency (as a qualifying condition to receive provider status under Medicare); the establishment of an HHS-approved training program for home health aides; and (Section 931) the establishment of regional intermediaries for home health care. The Administration now proposes to repeal or rescind these "low priority" reforms along with provisions in P.L. 96-611 which provide coverage for pneumococcal pneumonia vaccine under Medicare. To repeal these needed changes in the home health program, costing an estimated $35 million in FY 1982, is not only ill-timed but extremely shortsighted. At the same time that our "at risk" population of older Americans with chronic degenerative conditions is mushrooming, our various public and private home health programs are meeting the needs of only some 25% of those in need of such long-term care services. In FY 1978 Medicare home health expenditures ($520 million) constituted only 2% of total program outlays

while hospital care amounted to 74% of expenditures. As for Medicaid, only 1% ($211 million) of total Medicaid dollars was spent on home health - and three-fourths of this in New York State. In the absence of public policy changes, estimates are that in the year 2000 some 2 million persons - 89% of them over the age of 65 - will reside in a nursing home, an increase of 54%; by the year 2030 there will be nearly 3 million nursing home residents, a 132% increase. Yet even these projections do not reflect likely increased utilization due to changes in family structure. Expenditures for nursing home care are expected to more than triple by the year 1990 (reaching $76 billion) and remain the fastest growing area in the health sector. Further compounding this problem are other ominous trends. These include the fact that the growth in the number of nursing home residents continues to outpace the growth of the elderly population in general and, as the growth in nursing home outlays continues to exceed the growth in the elderly's income, that private pay nursing home residents will exhaust their resources, and "spend down" to Medicaid at an even faster rate in the future.

Our Associations believe that current efforts to scale back Federal spending in this area deserve thoughtful consideration and that this Committee should not foreswear innovative approaches. It is within this context and out of concern for long as well as

short term public spending that we have supported Senator Packwood and Senator Bradley's Title XXI legislation, "Non-institutional Long Term Care Services for the Elderly and Disabled Act." We hope that this Committee and the Congress will carefully consider this legislation when it is reintroduced. The information that this six year demonstration project will generate is needed before we can begin to effectively meet the long term care needs of our rapidly growing aging population.

Although a program to provide pneumococcal pneumona vaccinations to the elderly under Medicare would entail a net cost of $43 million in the first year, a recent study by the Congressional Budget Office shows that the inclusion of this service under Medicare would actually save the program $6 million in the fourth year and $11 million by the fifth year as a result of a reduction in costly (hospitalization). In addition to its cost effectiveness, it is estimated that 5,500 lives would be saved over a five year period. To start to counter these trends our Associations strongly recommend that the aforementioned amendments to the Medicare program be reaffirmed. To not allow these reforms to be implemented (effective July 1, 1981) would reflect an inadequate understanding of the dilemma this nation faces in the delivery of long-term care and preventive health services to an aging population, as well as being pennywise but pound foolish.

In addition, the Administration has proposed the elimination of the 8 1/2% inpatient nursing salary cost differential (saving $200 million in FY 1982) and the authority for civil money penalties for Medicare fraud. We support both of these cost savings measures as well as the Administration's proposal to institute competitive contracting for Medicare carriers and intermediaries. We oppose, however, for reasons already outlined less frequent surveys of skilled nursing facilities. This latter proposal would only serve to further exacerbate the already serious quality of care problems public pay patients encounter in participating nursing facilities.

At the same time, our Associations support a number of provisions recommended by this Committee during the 96th Congress, including: payments to promote the closing and conversion of underutilized facilities ($2 million in FY 1982 savings); and the limitation on reasonable costs and reasonable charges for hospital outpatient reimbursement.

However, a number of additional items have been proposed as alternatives or supplements to the Administration's proposed FY 1982 reductions which we find objectionable. The Senate Finance Committee staff has formulated several options for additional savings in the Medicare program - most of which are troubling. For the most part, these options would call for significant in-

creases in cost sharing liability on the part of beneficiaries. One type of proposal would increase the Part B deductible to as much as $100, index the deductible to reflect increases in program costs, and/or require that it be satisfied on an annual basis. One senses from these alternatives a conviction on the part of Committee staff that the elderly should bear a greater portion of the burden of these programs. To us this seems rather incongruous since the health care cost spiral continues to push the total cost of health care for older Americans well beyond their growth in income. The intent of such a proposal seems clear - to reduce utilization of Part B services on the part of the most vulnerable of the elderly, those in poor health and needing treatment. Older Americans already pay 3.4 times ($2,026/ CY 1978) the $596.82 per year an under - 65 individual spends on health care and 43% more of their budgets on out-of-pocket health care. A total of 37% ($746) of per capita outlays are from private funds -- exceeding the total per capita amount paid by those under the age of 65. When one factors in the deductibles, coinsurance, and premium payments required under Medicare, direct expenditures for health care services on the part of the elderly exceed the portion of their annual health bill covered by Medicare. Considering (Part B) physician services alone, beneficiary liability is approximately 69% of total physicians' charges due when deductibles, coinsurance and

unassigned claims are included. And as we know all to well, on only 45.8% of services do physicians accept Medicare payment as full reimbursement.

Furthermore, requiring coinsurance (we assume 20%) for home health benefits under Part A and B or Part B alone will only serve to further deny access to community based alternatives to nursing home care. As we have noted, access to home health care is already severely limited. Moreover, over half of all individuals with annual health expenditures exceeding $5,000 are institutionalized in long-term care facilities. Supplementing this Finance Committee staff proposal for home health as well as the increased Part B deductible solely for budgetary reasons is extremely ill-advised. It would represent a significant regression on the part of the Congress at the very time the elderly can least afford it. In combination with severe restrictions in Medicaid funding for FY 1982, any hope for progress in the development of a meaningful and cost effective continuum of long term care services will be lost.

C. Health Planning

Another area of concern to our Associations is the proposed phasing out of health planning over the 1981-83 period, supposedly in concert with the Administration's 2-year timetable for the development of a comprehensive package of health care financing reforms aimed at encouraging competition in the health sector. Frankly, to us this is not a "quid pro quo." It is highly unrealistic to expect such comprehensive reforms aimed at constraining the health care cost spiral to be implemented within this period. At the same time, the Federal government would be dismantling the only national cost containment program it has in place - and one with a proven track record of broad-based community involvement and success in containing health care costs.

The Administration proposes a reduction of $28 million in FY 1981 funding for State and local health planning programs, $100 million reductions in FY 1982, and a complete phase-out by FY 1983. Unfortunately, the Administration's view of health planning is unidimensional; that is, it serves merely a public utility function. To the contrary, our

Associations view health planning and the certificate-of-need process as a viable State and local decision-making

process with demonstrated successes. It remains one of the few tools government and health care consumers have in the battle against rising health care costs.

While many speak of the well recognized need to change our inadequate and cost promoting reimbursement system, this alone will not solve the problem. We have to look at the supply side, and through the health planning process, continue to discourage, disapprove, or modify capital projects that are not effective. It seems ill-advised to jettison federal financial support for local health planning at the very time it is needed most and when our growing senior population is <u>most</u> vulnerable to the health inflation spiral.

Health planning is impossible to evaluate on the basis of outcome measures alone. In fact, in terms of its clearest objectives the performance of the planning process is best reflected in things that did not happen or in things that happened in a qualitatively better or more responsive fashion. For example, annual expenditures for health facilities construction has continued to decline in constant dollar terms since the early 1970's, falling 26% in the last four years (1976-79). Planning agencies have also disapproved approximately 20% of the $5 billion per year reviewed by local planning agencies. This process, in successfully avoiding capital expenditures where demonstrated surpluses already

exist, help reduce Medicare and Medicaid outlays otherwise expended to maintain unnecessary and costly beds, facilities, and equipment. And yet, the real dollar savings in public programs and systemwide come with projects that are delayed or modified as a result of Health System Agency (HSA) review prior to formal submission of the project under either CON or 1122 review. In part as a result of health planning, hospitals' own institutional planning - as reflected in the quality of their capital expenditure proposals - has improved dramatically in the last five years. In a 1979 national survey of hospitals ,64% said they had expansion plans and 21% of these indicated that they had postponed or dropped such plans due to the need for planning agency approval.

It is also interesting to note that on a per capita basis more expenditures are being approved in rural areas than in urban areas and that planning agencies are approving much higher net increases in hospital beds in areas of high population growth while fostering net decreases in areas of population loss. At the same time,approval rates have increased sharply for needed alternative, new, or "other facilities and services"when compared to approval rates for hospitals and nursing homes. This would seem to counter the arguments being advanced by the Office of Management and Budget (OMB) that market access (and thus competition) is being unwisely restricted by CON, 1122 review and the health planning process in general.

Other positive changes at the local level,readily discern-

able but not easily quantifiable, include the timely allocation of new resources into underserved areas, educating the public about health and health care problems, and creating new coalitions of business and labor to tackle health care costs. The cost -- less than one dollar per year per capita for all health planning in an industry costing more than $1,000 per year per capita and the elderly more than $2,500 per year -- is relatively small. Should health planning be eliminated it has been estimated that there would be a 50% increase in capital construction over the next 4 years, or $10 billion more than under the current system.

Our Associations believe that the health industry's Voluntary Effort (VE) to contain health care costs offers older Americans very little in the way of relief. We are disturbed at what seems to be a growing tendency on the part of the Federal government to eliminate or de-emphasize its own capacities as a prudent buyer in the name of market forces and to back off from its responsibility to constrain our rapidly rising national health bill (and the Federal share of it).

Simply stated, the alternative advanced by the Administration, implementation of pro-competition legislation, is not a near-term possibility. By the same token we would note that planning is and will remain an essential to the implementation of any competitive health system. Local

planning agencies are well positioned to provide major consumers and purchasers of health care information that is needed in order to make those informed and price conscious choices that are basic to the effective functioning of a competitive system. We believe that organizations such as ours must work with the Congress and the planning community to strengthen the local health planning process, making it even more effective and responsive to local needs.

At the same time we must realize that health planning is a recent development and must have time to develop. Results cannot and should not be expected overnight. To eliminate Federal expenditures for health planning only 2 or 3 years after much of the machinery for this process was put in place would epitomize "waste" in government spending. To quote from an unexpected source, Congressman David Stockman said during the debate on funding for health planning in the 96th Congress, "if funding reductions are to be made, it seems far more sensible to me to channel the bulk of available funds to the local health planning effort, rather than to State or Federal health planning administrators who are further removed from the immediate needs of the community." We agree with Mr. Stockman's assessment and we hope you will when the Administration's proposed phase-out of local health planning is considered.

D. HMO's

Starting with rescissions of $37 million to the loan fund in FY 1981, the Administration proposes completely phasing out Federal support ($54 million in FY 1981) for the development of Health Maintenance Organizations (HMO's) by the end of 1983. We find this proposal inconsistent with the stated intent of the Administration to encourage the development of alternative health care delivery systems, the necessary lead times required of most HMO's to become fully viable, the demonstrated cost savings HMO's generate, and the significant financial support State and Federal government provides (primarily through tax expenditures) to such high-cost institutional providers as hospitals and nursing homes. We would contend that these modest levels of Federal financial support are needed to expand access to the HMO alternative in those many areas of the country where private (venture) capital has not been invested in HMO development, yet where there is significant potential for growth and where health care costs are out of control. Indeed, the major impediment to HMO development is not overly restrictive requirements for Federal qualification found in the HMO Act but the inadequacies of our reimbursement system. Should the Congress decide to further limit access to HMO's by eliminating Federal support during the initial years of development, we would hope that the Congress would act to provide elderly Medicare beneficiaries equal access to HMO's

through changes in the way HMO's are reimbursed for services. As individuals, the elderly for the most part can not enroll in HMO's. Changing reimbursement from a cost plus to a prospective, pre-payment basis for Medicare beneficiaries with required open-enrollment periods would act as a powerful incentive for the development of the HMO option for all segments of the population. Clearly, retrospective, cost based reimbursement is not financially attractive nor viable for all but the largest and most capital-rich HMO's (e.g. Kaiser Permanante).

While our Associations' contention that Federal financial assistance should be maintained at current levels is, for the most part, the product of our deep concern over escalating health costs, we do believe that the current support program should be more carefully targeted and selective. The focus of this program should be on areas with high growth potential as well as on HMO's serving special or otherwise unserved population groups. The latter goal may not be as easily a subject of prescriptive financial analysis, and HMO's serving such high risk groups are likely to find initial private financing unavailable without early Federal financial support in the form of loans, loan guarantees and grants.

E. Alternative Suggestions for Reducing Federal Health Care Outlays

Our Associations have a number of suggestions to make for reducing Federal outlays for health care that we believe are preferrable to those being advanced by the Administration.

First of all, as we all know, hospital costs (which represent some 40% of all health care costs) continue to increase at rates far in excess of the general rate of inflation, driving up Medicare and Medicaid costs. In January of this year alone, hospital costs (CPI-U) increased 2% while the all items CPI rose 0.7%. Our Associations have long urged the Congress to place federal limits on increases in hospital revenues per admission. Such an across-the-board approach would not single out Medicaid or Medicare beneficiaries for special restrictions.

Since the Congress has rejected such a uniform imposition of limitations on the rate of increase in hospital costs, we believe as an alternative it should encourage the adoption of State rate setting programs (a total of seven States already have mandatory rate review programs). This would reduce Federal and State outlays as well as payments by private purchasers of hospital care. We would also suggest

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that the Congress direct the Federal government to share a greater portion (e.g. one-third) of the savings in Medicare and Medicaid costs that are achieved through such rate review with the States. Providing financial incentives for additional States to initiate effective rate review is in concert with the goals of H.R. 2626, the Hospital Cost Containment and Reporting Act of 1979, as approved by the 96th Congress. Based on rather conservative assumptions, the Congressional Budget Office (CBO) estimates five year (1982-86) savings of $2.4 billion to the Federal government from such an initiative (assuming 25% of costs are reviewed and 1/3 of Medicare savings passed on to the States).

Since 1975 revenue losses from tax expenditures have been rising at a rate of 14% per year while the annual rate of increase in direct federal outlays has been about 11% over the same time period. Therefore, in the area of tax expenditures, our Associations believe that the exclusion from taxable income of employer-paid health insurance premiums deserves the Congress' attention. This exclusion of subsidy will reduce tax revenues by $21.4 billion and social security trust fund revenues by another $7 billion in FY 1982. Our Associations support limiting this exclusion to a fixed, regionally determined monthly dollar figure (e.g. $120) if, as a "quid pro quo," some form of catastrophic or stop-loss protection was adopted as a required

part of all qualifying health plans and if such benefits were conveyed to individuals upon retirement. This minimum, catastrophic protection should include some degree of protection against long-term care costs. Cumulative five year savings from the imposition of such a ceiling would approximate $17.9 billion.

On the supply side, severe and immediate limitations should be placed on the tax exempt status of hospital bonds.[2/] Approximately half of the funding for hospital capital projects comes from tax-exempt bonds ($3.4 billion of these bonds were issued in 1979). The direct Federal revenue loss from all outstanding hospital bonds in FY 1982 will be $700 million. We seriously question the efficacy of this subsidy which allocates resources on the basis of a hospital's financial standing rather than the need for such facilities. Also, the magnitude of the subsidy promises to increase greatly should local health planning and the certificate-of-need process be phased out as the Administration has proposed. Such tax-exempt status for hospital bonds in those many areas of our country which are overbedded also further escalates Medicare and Medicaid reimbursement levels for empty, unneeded beds. Every $1 saved by borrowing hospitals costs $1.33 in lost Federal revenue. [3/]

2/For hospitals able to demonstrate the need for new construction in a growth area, this subsidy could be retained.

3/CBO, Reducing the Federal Budget: Strategies and Examples, FY1982-86, February 1981.

V. THE LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

The Associations have serious concerns about combining the LIEAP program and the AFDC emergency assistance program into an Emergency Energy block grant to the States and funding it at substantially reduced levels. Because States would establish their own priorities and exercise total program control over resources, we are concerned that the elderly's energy needs will be "lost in the shuffle."

Currently the program is funded through the Windfall Profits tax which in essence redistributes the taxes levied on the high profits oil companies are experiencing due to oil price decontrols to low-income households which can ill afford the skyrocketing costs of home energy. The States

do not receive revenue from this tax and may therefore be reluctant to pick up their share of the costs for this assistance. It is important to note that under the current program, 95 percent of the monies are already in the form of block grants to States which draw up their own plans, subject to HHS approval, for dispersing available funds. Currently, Federal guidelines do allow States some flexibility in determining local needs.

Oil price decontrols (and expected gas price decontrols) are Federal initiatives. It is incumbent upon the Federal government, therefore, to continue to provide energy assistance to those in need. We would suggest that it would make more sense for the various energy assistance programs to be consolidated at the Federal level rather than continuing the current fragmented approach of placing some at the State level (through the massive block grant) and keeping other initiatives in various agencies in Washington. Such a coordination of programs would make current benefits more accessible, eliminate duplication or overlap, and fill in the gaps to meet needs where current programs do not. Furthermore, streamlining programs would reduce administrative costs, and within budgetary constraints, make it possible to reach more needy persons.

In our view, this consolidated national energy assistance program would have three major components: direct assistance, weatherization, and outreach. Each state would have the flexibility to determine how best to meet these three goals, which would give them more flexibility and allow them in turn to consolidate fragmented energy assistance programs within their jurisdiction.

VI. CONCLUSION:

Anti-Inflation Strategy Must Be Comprehensive and Multi-Faceted

Our Associations have been observing inflation closely for over a decade. In the process, we have come to recognize the commonly accepted myths concerning the origins and nature of modern inflation. These myths are still prevalent in the press, in the minds of the public, and in the minds of many policymakers. We will not gain much ground in the battle against inflation unless these myths are abandoned.

Federal deficit spending is blamed by a large proportion of the public as the entire and sole cause of inflation. Without dispute, it is an important factor in inflation, but mathematically it cannot remotely account for the large price rises in the economy, which are now over $250 billion a year. The printing press, the public's shorthand expression for expansive monetary policy, is probably the number two whipping boy for inflation. Labor unions' "excessive" wage demands are blamed. Administered prices are blamed. The OPEC cartel has also been held solely reponsible for recent inflation.

In our view the wage/price spiral represents the backbone of our current inflation problem. A study made in 1980 by DRI mathematically established the wage/price spiral as the largest component of modern inflation. If inflation is running between 12% and 13% a year, the wage/price spiral is probably contributing about 8% to 10% to the rate, representing what is commonly labelled the "hard-core" rate.

Some policymakers have argued that the elderly should share, along with other groups of society, in government spending restraint necessary to help bring inflation under control. Since it is impossible to make the elderly inflation-proof, we agree that controlling inflation must be our priority concern and recognize that spending restraint is <u>one</u> part of the strategy necessary to curb inflation. However, before enlisting the elderly in any inflation battle and accelerating the rate of decline in their real incomes and living standards, we would want reasonable assurances that government will pursue an effective anti-inflation strategy that would bring down the rate in a short period of time and also provide for an equitable sharing of the "pain" such a strategy must inevitably entail.

Although no one can accurately predict to what extent balancing the budget will dampen the public's inflationary expectations and help to unwind the wage/price spiral, some economists estimate that, at most, balancing the federal budget will shave a few percentage points off the aggregate inflation rate. Without specifically dealing with cost-push factors, we do not expect inflation to be radically slowed in the coming months. Supply-side economics, based on a revival of savings and investment in new capital facilities, is inherently a longer-term, anti-inflation strategy.

To deal with inflation in the short-term, our Associations recommend the following combination of policies:

* First, a strong incomes policy must be pursued; the President should be given standby authority to impose wage/price controls on a selective basis.

* Second, the federal budget should be brought into balance over the next two or three years and maintained in balance over the business cycle.

* Third, money supply growth must be gradually reduced and ultimately kept in line with real growth in the gross national product.

* Fourth, competition in the economy should be furthered by deregulation where appropriate, removal of import quotas and refraining from further government and private actions which increase prices.

We would like to emphasize the importance of using a strong incomes policy to attack the wage/price spiral. Incomes policies can range all the way from exhortations (or "jawboning") by the President or other leading public figures to a full-blown program of monetary wage/price controls modeled after the programs in effect during World War II and the Korean War.

In our opinion, in order to deal effectively and resolutely with the wage/price spiral and inflationary expectations, the President should be given standby authority to impose price and/or wage controls in those sectors of the economy that are

leading the inflation parade. The health care industry is an outstanding example of just such a sector; the rate of escalation in health care costs has been clearly out of control for some time.

Standby authority for the implementation of controls and an expressed willingness to use them, if and when necessary, will immediately alert the public to the fact that the government is serious about reducing inflation to tolerable levels within two to three years. The more forcefully it is indicated to the various groups that they must cooperate in the common effort, the less likely it is that the standby authority will have to be exercised in more than just a few cases.

We would like to stress that although we support a gradual reduction in the rate of growth in the money supply and fiscal restraints, we cannot depend on these policies to dampen inflation in a reasonably short period of time. While these policies take time to be effective, inflation will be doing great harm to the economic and social fabric of the nation. Dependence on restraining monetary and fiscal policies alone to reduce inflation has led Great Britain into exceptionally high unemployment and costly industrial stagnation. In the United States, we must deal directly with structural "imperfections" in the economy, which are not going to disappear by waving "macroeconomic" wands or by repeating incantations of the virtues of supply-side economics.

In summary, our Associations support the Administration's effort to reduce Federal expenditures, balance the budget, reduce unacceptably high rates of inflation, and revitalize the economy. However, we do not ascribe to the theory that such fiscal restraint in tandem with massive tax cuts will abate the inflation spiral - the paramount concern of older Americans. Until government indicates it will pursue an effective, multi-pronged anti-inflation program that includes not just fiscal and monetary restraint but also a tough "incomes" policy that will bring down inflation rapidly and spread the "pain" of curing inflation in an equitable manner, do not expect the elderly to be willing to accept proposals (such as reducing social security's cost-of-living adjustment) that would reduce the only inflation protection they have, but otherwise leave double-digit inflation unchecked; and be assured that cuts in health programs we have described above will only serve to further exacerbate the increasingly serious problems the elderly face in coping with inflation and in receiving quality health care. There are numerous alternatives to the Administration's proposals we have discussed that would act to constrain on-budget expenditures of the Federal government while maintaining a "social safety net" for the truly needy. We hope this Committee and the Congress fully realize the importance of such programs as social security, Medicare and Medicaid to the elderly so that you will seriously and carefully explore other options prior to supporting the Administration's proposed budget reductions "entoto".

STATEMENT OF JACOB CLAYMAN, PRESIDENT NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY BETTY DUSKIN, RESEARCH DIRECTOR FOR NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. CLAYMAN. Mr. Chairman, Senator Moynihan, earlier in the proceedings Senator Moynihan indicated a concern about the lack of public interest. He was particularly worried when the press wasn't here. That is a concern that I have too, not about the press, but the plain fact is that the American people really don't know what this is all about yet.

There is great confusion. The facts are never laid out straight and clear and understandable to the ordinary public. But it will come ultimately, and I assure, at least in my humble judgment, Senator Moynihan, in the not too distant future that there will be an understanding of this total program.

And it may very well be that the necessities of procedure, congressional procedure, demanded haste but in our judgment it is an unseemly haste and action on the budget cuts.

I come from a senior citizens organization which represents basically the poor and the moderate income segment of our society, and so I have a very special interest in those people, and I keep repeating almost ad nauseam a few facts generally not comprehended yet. In much of our society, particularly in the last couple of years, Senator Moynihan, academia and others have been obsessed with the notion that in the main the senior citizens of America are in good shape.

They don't need much help. There are a few at the bottom of the barrel that may need assistance, but quickly I repeat these figures; they must be kept in your mind; if I had a brand, I'd brand them on everybody's memory.

In 1979—it is a little higher now—the poverty level was $3,479, a single person, that means $66 a week. For a family of two, it was something like $4,394, or a weekly salary or weekly income of $84 a week.

And when you also include in that category, as per necessity, the near poor, literally one-forth of all the elderly in America, roughly 6 million people live in poverty. And if there is an assumption that there is a safety net under these 6 million, I'm afraid we who work with the elderly do not discern it at all.

For example, and I'll do this quickly, you can't break the fall of hundreds of thousands of people in poverty with these cuts. In the low-income energy assistance program, when you cut it fully by a fourth and add double jeopardy by sending the three-quarters to the States, it just won't work. Hundred of thousands will fall through that fragile net.

Housing: We in the National Council of Senior Citizens are very much concerned with this problem. We have been working with it for years now, and the suggestion is being made, whereas it is as of now and heretofore that an aged occupant would be required to pay 25 percent of his income for rent, the balance subsidized by the Government.

This will go to 30 percent. It has been rationalized by some; I trust the figures are correct, that there will be 730,000 elderly who will pay $202 more per year in rent.

Now, that doesn't sound like much, I suspect, to those of us who are in the so-called middle class; we can manage $202 a year quite easily, but to an elderly couple or an elderly person, that means another form of deprivation, whether it is food, whether it's clothing, whether it's health care, whatever. And if I didn't know that it wasn't intended as such, I would almost call it rather mean spirited.

Medicaid: In some of the areas of health services to the elderly—medical services to the elderly would be cut by 25 percent and, again, shipped to the tender care of the States, and the care will vary from State to State.

Legal services: 1980, about 400,000 elderly people were assisted by the Legal Services Corporation. That means that finally, at long last, these people who pretty much have been outside of the law in terms of receiving the benevolent protection of the law, and only in recent years have had the opportunity, on a free basis, to present their grievances to the courts to defend what they conceive to be their rights. It is their only chance at what we call justice. And this is going to be eliminated if the will of the administration becomes the law of the land.

Well, there are other things that I would have talked about, but I don't want to abuse that red eye that is staring at me and so that is our case, except as we presented some written testimony and trust it will become part of the record.

The CHAIRMAN. The entire statement will be made a part of the record.

Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman.

I would like to thank both our witnesses. They have prepared very careful testimony.

We are running a little bit late this morning, so I won't ask questions, but to tell you that you have raised questions, and you certainly have my sympathy in most of the matters you've done, and, more importantly, we are in your debt for laying out some of the facts of these subjects for us, because we have to take them up in actual legislation.

The CHAIRMAN. I didn't have an opportunity to hear Mr. Hacking in full, but I appreciate the comments I did hear.

Senator MOYNIHAN. It was very fine work.

If you are ever looking for—if you ever get tired downtown, we could use you on Capitol Hill

The CHAIRMAN. I can't quarrel with anybody who says we shouldn't do anything, but we are in the fix we are now because of past policies, in part.

I would guess one thing that affects people you represent is inflation and high interest rates, and all the other things that go with it, and if we just say, well, we are not going to cut any of these programs, or any other programs, I don't know what the alternatives are, and I think we are going to have to make some hard decisions.

For 26 years we have followed one course, maybe it is time to look at another.

Mr. CLAYMAN. I'm moved to make a response, but maybe we don't have the time.

The CHAIRMAN. We have a couple of other witnesses. I know you were not a strong supporter of candidate Reagan, but I hope that there is some area since he is now the President, you may see fit to support him.

Thank you.

[Statement follows:]

STATEMENT BY JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, Members of the Committee, I am Jacob Clayman, President of the National Council of Senior Citizens. The National Council represents over 3.5 million older Americans through 4,000 senior citizens clubs and councils located in every state of this nation. As the largest organization of clubs representing low- and moderate-income elderly, NCSC is concerned about the detrimental impacts that the President's proposed budget will have on elderly people.

We feel that something ominous is happening in America. For the first time in over fifty years—since the administration of Herbert Hoover—a President of the United States has announced a complete faith in the ability of private industry to restore the economic health of the country, coupled with a significant rejection of the government's responsibility for the well-being of its citizens.

As an indication of this dual principle, the Administration has submitted to Congress a budget that would markedly reduce or drastically cut back on many of the programs created over the years to assist the poor. At the same time, it would provide tax breaks for wealthy individuals and corporations. Cuts would be made in programs providing health care, nutrition, legal services, day care, transportation, job training and employment, and senior services. The elimination of these services would create a severe hardship for tens of thousands of Americans, many of whom are elderly.

The philosophy behind the current proposals for the budget is that if we cut federal spending for the poor, and allow tax breaks for the rich, we will reduce inflation and create full employment. There are economists on every side of this suggested strategy, including those who believe it will work, and others who believe it won't. But one thing is clear to everyone: The new strategy will be carried out at the expense of the poor and the disabled in our society.

These observations on the budget should be immediately apparent:

Firstly, there is no serious evidence that the prescription of reduced government spending to achieve a balanced budget will actually end inflation in America.

Secondly, most of the budget cuts are aimed at those in society who are generally voiceless, defenseless, and unrepresented.

Thirdly, the Administration's call for a ten percent cut in taxes for each of the next three years, for a total cut of thirty percent, is designed to benefit wealthy individuals. There is no evidence that these generous tax breaks for the rich will create more jobs or end inflation.

It should be noted that one of the stated aims of the Administration's economic plan is to end unemployment in America. It has been estimated, however, that if the Reagan plan is enacted, one million, one hundred thousand new jobless will be added to the rolls. There will be other impacts as well.

The National Council of Senior Citizens has carefully examined the President's budget proposals. We have concluded that many of the proposals threaten the income security of the elderly and that they are being asked to shoulder a bitter burden. Whether the proposed actions are to decrease cash income or to reduce services and supports, the end result will be a loss of income. The elderly will have less money to purchase the basic necessities most people take for granted, and they will have to use their reduced incomes to purchase even more necessities than before because of the potential losses in food stamps, in energy assistance, and in a host of services.

Millions of senior citizens already have inadequate incomes. Fourteen percent of the people over age 65 have incomes below the poverty level, and 25 percent of the elderly live a tenuous existence just above poverty. The slightest loss of income will plummet many people into the pain and humiliation of poverty in spite of their having worked hard throughout their lives. If not for the development of social welfare programs, many more older persons would live in poverty. Yet, these very programs are about to be placed on the budgetary chopping block.

I am here today to discuss how the proposed budget will impact the income security of the elderly. It has not been difficult for us to understand how the cuts will reduce or eliminate the programs which help the elderly. However, it is exceed-

ingly difficult to understand why our President would sacrifice the well-being of so many people for budgetary short cuts which may ultimately have more costs than benefits.

The budget proposals do not just represent the ways our government will try to save money. They represent the insensitivity of our new Administration to the basic rights and needs of individuals who, through no fault of their own, depend on others. These proposals also represent an insensitivity to the consequences of policy decisions made solely on the basis of dollars.

Our public policy-makers must be reminded that on the other side of every budget cut there are *people* many of whom are dependent upon the government, not because they want to be, but because they have no alternatives: Many of these dependent persons are low-income elderly whose meager incomes are devastated by the cost of the basic necessities of life—housing, food, medical care, and home energy. The federal government has interceded on behalf of these people in an attempt to assure that they do receive these necessities, and can lead reasonably comfortable lives.

If the elderly lose access to these basic elements, many of them will be forced to make trade-offs. For example, some may have to decide between keeping warm or eating adequately, between buying prescription drugs or paying rent. This is not belt-tightening; it is not simply doing without. This, gentlemen, is forcing people to accept conditions which threaten their very survival. In good conscience, can you accept this as a consequence of budget cuts?

Many of the budget proposals will impact the income of elderly people, particularly since they will have to stretch their incomes to pay more for the basic goods and services. I will now discuss some of the particularly significant proposals.

SOCIAL SECURITY

Proposals to eliminate the minimum benefit, and to reduce disability and survivor benefits, all have implications for the elderly both today and in the future. Social Security is a system. It is composed of many parts, all of which are essential, legitimate functions of the nation's social insurance program.

This concept is paramount in considering the impact of any of the Social Security proposals on the elderly's income security. We must ask ourselves: Do we want to nibble away at the vital components of the system, pretending we are seeking budgetary savings, when we are in fact eroding the whole system and the public's confidence in it? Is that not really the greatest threat to income security?

There may be no system left if we start attacking the income of poor elderly widows for the sake of what is thought of as a "windfall" for a small few; if we deprive the disabled, deceased, or retired beneficiaries' children of a better chance at productive lives through education by regarding them only as "students"; or if we forget that 75 percent of disability beneficiaries are over age 50, and most have chronic disabling diseases that eliminate work as an alternative.

What comfort can the elderly take from being told that "basic" benefits will not be cut when they know in their heart that it only means that they are second in line for the guillotine instead of first?

FOOD STAMPS

Almost 2.5 million or ten percent of all food stamp recipients are elderly people. This is close to ten percent of the total elderly population, and many more are eligible. Thirty-four percent of the food stamp recipient households derive their income from Social Security and Supplemental Security Income for the blind, aged, and disabled.

The proposal to reduce eligibility for recipients by setting gross income eligibility at 130 percent of the poverty line would remove five percent of total recipient households from the food stamp programs, and it would reduce benefits for many others. Among these households and individuals would be many elderly people. Current eligibility is based on net income, acknowledging, correctly in our view, that a family's ability to buy adequate food depends on its discretionary income, not on income that it is forced to spend in order to have a roof over its head or the carfare to get to the doctor.

The other proposals would have the effect of reducing disposable income since the shelter and standard deductions would be frozen. Food stamp benefits would not be adjusted to reflect income loss as inflation causes the price of other necessities to rise. The elderly also would not be allowed a larger medical deduction to reflect their inordinately high medical expenses. This would erode disposable income as well. The loss of food stamp benefits has more than income effects. It also has

serious health implications, and potential public and private medical expenditure increases which should be considered.

LOW-INCOME ENERGY ASSISTANCE

The Low-Income Energy Assistance Program has been set up to help people meet the rising cost of home energy. Forty-two percent of the people who benefited from this program in 1980 were elderly. This year the program will provide $1.85 billion to eligible consumers for the payment of heating bills during the winter and cooling bills for the summer.

This program operates through state welfare offices or economic opportunity offices. Although eligibility levels vary, generally speaking, an individual with a monthly income under $395 or a couple with an income under $522 will qualify for aid.

How much help each person can receive depends upon a number of factors, but the most important one is the amount of energy a home or an apartment uses compared with household income. Most states are providing a maximum of $750 per eligible household, although the actual benefit is usually between $100 and $200.

The budget proposal for the program could end this assistance for 25 percent to 100 percent of the elderly now on the program. They will be placed in "double jeopardy" along with the other recipients. The proposal is to slash the program by 25 percent and to place it into one large block grant to each state for emergency assistance. Not only will about 25 percent of current eligibles be declared ineligible, but it is possible that the entire program will be eliminated by many states.

For the elderly, the loss of assistance in paying energy bills will have serious health as well as income impacts since the elderly are at high risk of complications such as hypothermia and pneumonia.

The threats to income security of the elderly does not stop with these three proposals.

HOUSING

Nearly one-half of all publicly subsidized housing is used by the elderly. The budget proposals for housing programs would require that the elderly pay more for this housing, if it is available should the proposals be approved.

The Administration's proposed budget cuts will have a profound effect on at least three major programs which provide affordable housing for lower income elderly persons.

The Section 8 rental subsidies and Public Housing Program are the major housing program now available to lower income persons living in rental housing. They do not have to pay more than 25 percent of their income for rent; the remainder of the fair market value for the rental unit is the Section 8 subsidy amount.

Forty-one percent of the 1,744,805 households currently receiving rent subsidies are elderly households. People receiving these subsidies reside in either existing rental units covered by the program or in newly constructed and rehabilitated rental housing built as a result of this program.

There are two ways in which the Administration's proposal will drastically affect this program. The first way is to raise the rents of all present and future participants in the program from the present 25 percent of their income to 30 percent of their income. The second way is a drastic reduction in funding which will lower the number of households participating in the program.

The proposed cut would eliminate as many as 34,850 of the 722,415 elderly households from the program in the future, as well as raise the rents of all. Considering that the program has never received sufficient funding to meet housing needs, the cuts proposed by the Administration will virtually eliminate this program's ability to provide affordable housing for the elderly.

Section 202/8 Direct Loan Program for Housing for the Elderly and Handicapped makes available to non-profit sponsors 40-year mortgages at U.S. Treasury interest rates for new construction or substantial rehabilitation of housing for use by lower income elderly and handicapped people. Section 8 rent subsidies are provided for all residents of the buildings constructed under this program.

To date the Section 202/8 program has provided new affordable housing for some 105,722 lower income elderly households, but there are strong indications that attempts will be made to eliminate or radically restrict the program in the future.

Another threat to the Section 202 program is the potential ineligibility of the Section 8 Rent Subsidies. The rents necessary to support the Section 202 projects—even at Treasury interest rates—would be above the allowable maximum rentals to which the Section 8 can be applied. In any case, the appropriation requested includes no increase in funding, so the number of households served by this pro-

gram (now approximately 17,500 new households per year) will be cut by 10-15 percent as construction and maintenance costs rise.

Farmers Home Administration 515 Rural Rental Housing Program: This is for all intents and purposes the only program providing for the construction of affordable rental housing in rural areas. Since twice as many rural elderly as non-rural elderly live in deficient housing, and the rural elderly pay more for their housing, continuation of this program is especially critical. This program provides for 40-year mortgages and rent subsidies similar to Section 202.

Since the program's inception in 1961, it has provided new affordable housing for approximately 191,578 households, of which at least 65,416 (one-third) are elderly households. Currently, of the 30,000 units built each year under this program, 10,000 are specifically designated for the elderly.

The Administration is calling for an 11.5 percent cut in the program for fiscal year 1982. Since the rent subsidies used in the program are usually Section 8 subsidies, reductions in that program will also severely affect the Section 515 program.

HEALTH CARE

The President has proposed major reductions in funding for Medicaid and programs which meet distinct health and social service needs. These cuts will seriously threaten the health of the elderly, the poor, and the disabled. They will have to pay more money from their already-strained pocketbooks, and may find that the only medical facilities to which they have access will be closed.

Low-income elderly, with or without Medicare, need Medicaid. It buys basic health care and service, such as nursing home care, not covered or insufficiently covered by Medicare. Since the elderly's health care expenses are three-and-one-half times greater than those of any other group, and since Medicaid pays 57 percent of all nursing home stays, losing Medicaid coverage could be disastrous to senior citizens. They will pay more for health care or will be deprived of this basic human right.

The proposal is to "cap" the federal Medicaid contribution. In fiscal year 1981, $100 million would be cut from the funds the states need to continue their present programs through September. In fiscal year 1982, this contribution would increase only five percent over 1981. (In 1980 alone, medical inflation was ten percent.) During 1983–1986, the federal contribution would increase no more than the annual inflation rate. Funding would not change even if the states' costs increase. The cap would be in effect for as long as it takes the Administration to formulate, legislate, and implement health care reforms.

The President has proposed to give the states more flexibility to administer their Medicaid programs. However, since the states would be less accountable to the federal government, they could use the federal money for Medicaid services that are currently paid for from local monies. Fewer services will be provided and fewer people who need medical care will receive it.

The proposals will have income effects on the elderly. Those who can pay for medical care will spend more of their income on medical care. In addition, the "savings" will become costs in some areas and will raise prices in others. Some of these consequences can be expected:

Benefits and eligibility levels under Medicaid will be restricted. Recipients will be removed from current rolls. The states will have less Medicaid money. Since few states can put more money into their programs, they will provide fewer benefits to fewer people instead.

State and local taxes are likely to increase to allow for even modest growth or to avoid denying benefits.

The poor will become ill from lack of early treatment and require more expensive care. People will receive inadequate medical attention, and they may postpone seeing the doctor until they are seriously ill, needing hospitalization. Not only will this endanger health, it will result in higher Medicaid costs rather than savings.

Health care costs will rise. Without Medicaid, people will be unable to pay their medical bills. The community or people with Medicare and other health insurance will pay higher fees to absorb these costs.

Health facilities will close. Inner-city or low-income community hospitals and clinics in low-income areas primarily serve Medicaid recipients. These institutions will be forced to shut down if they lose Medicaid revenue.

Finally, the problems of high cost in medical care will not be solved. The price of health services for all people is high, and yet this proposal does not offer any remedies. To cap the federal funding of Medicaid without solving these problems is unjust and counterproductive. It is not a vicious attack on the budget but on those

whom the President described as "those who through no fault of their own depend on the rest of us."

The health and social services grant consolidation proposal threatens many programs which service the elderly: senior centers, visiting nurse and homemaker services, meals-on-wheels, low-income energy assistance, community health centers, and mental health services.

These programs, plus 33 others, are now separately funded because there was a time when the states were unwilling or unable to finance them in spite of a nationally recognized need. The proposal will return us to that time.

All 40 programs would be consolidated into four categories. Funding would be cut by 25 percent and given to the states in "block grants." The states, in effect, would have four large pots of money to use as they please, with virtually no federal constraints to assure that the money benefits people in need. If a state places low priority on caring for sick older persons or on helping low-income persons pay their high utility bills, the block grant money will be spent elsewhere. Some programs will cease to exist.

LEGAL SERVICES

During 1980, about 400,000 elderly people were assisted by Legal Services Corporation (LSC) lawyers. Now the Administration has asked Congress to cut off all future federal legal aid for the poor, thereby totally eliminating the LSC which has been in existence since 1974. It receives funds from Congress and in turn distributes the money to local, community-based programs that provide direct legal services to the poor.

LSC lawyers generally handle routine civil cases: utility cutoffs, housing, Medicaid and Social Security complaints.

LSC is currently funded at $321.3 million for fiscal year 1981. There are about 320 legal services projects presently operating in more than 1200 neighborhood offices and serviced by 5000 lawyers.

There are about 30 million low income persons nationwide who are financially eligible to receive corporation-funded legal assistance. During fiscal year 1980, LSC grantees handled approximately one million legal matters for the poor. While legal services to the poor have greatly expanded in recent years, it is estimated that still only a small percentage of the legal needs of the poor are presently being met.

During 1980, about 400,000 elderly were assisted by LSC lawyers. In addition, the elderly benefit from LSC through the efforts of the two branch offices of the National Senior Citizens Law Center, in California and in Washington, D.C. which provide back-up support for lawyers in the field and represent the elderly's legal concerns to relevant parties in Washington. Termination of LSC would not only mean that the elderly poor would have to pay for legal services (though few could afford to), it would also mean they would lose access to legal means of assuring their income when they experience problems receiving their entitlement and support services. It would leave a huge gap in legal representation for the elderly.

TRANSPORTATION

The Reagan Administration has asked for substantial reductions in funds for public transportation which, if approved, would mean drastic cut-backs in service on local transit systems as well as on commuter trains and Amtrak.

Federal mass transit operating subsidies would be phased out gradually, with a $.3 billion budget cut in 1981, leading to complete elimination of such subsidies by 1985.

Under current law a mass transit system receiving federal subsidies may not charge more than half-fare for senior citizens or the handicapped during off-peak hours. An end to federal subsidies could very likely mean an end to guaranteed senior discount fares.

In submitting its proposal on mass transit, the Administration said that it would be up to state and local governments to decide "whether to (1) raise State and local subsidies, (2) increase transit fares, or (3) reduce services."

Budget cuts proposed for Amtrak would be $431 million in 1982, increasing to $1.1 billion in 1986. Amtrak fares would be raised to cover the loss of current federal subsidies, raising the current fare to approximately double on short distance trains, and by approximately 50 percent on long haul trains. The financial burden will be shifted to either Amtrak passengers or State governments or certain trains will be eliminated.

What should now be clear is that the threats against the income security of the elderly are not confined to just a small portion of the President's budget proposals. In addition, it should also be clear that if the proposals are approved, the elderly

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living in or near poverty will be confronted with spending a greater proportion of their incomes on basic needs or struggling to survive with these needs unmet.

In the view of the National Council of Senior Citizens, therefore, budgetary savings which reduce programs that benefit the poor should not be approved. These programs were created to fulfill a national priority and I see no evidence that this priority has or should change. In this time of economic instability, these programs need to be reinforced—not cut—to help those without sufficient resources or alternatives to protect themselves from the ravages of inflation. To cut the programs may, in fact, lead to greater social costs or increased federal expenditure in other areas such as health care.

This government help need not be passive. There are current programs which encourage employment of low-income elderly people. One of these programs—the Senior Community Service Employment Program—exists under Title V of the Older Americans Act. This program, which is an important source of income to approximately 70,000 low-income elderly citizens with poor employment prospects, has many secondary benefits. It brings the elderly back into the mainstream of life, restoring dignity and returning mature minds and skills to the service of the community. It fills jobs that need doing, satisfying unmet needs in the local community. It also provides wages instead of public assistance programs which otherwise would be needed by these people. Finally, the high employability of many older persons and the useful part-time work they can perform benefits the elderly and the community.

Although the success of this program has been widely recognized, it too is being exposed to the vicious cycle of budget cuts. The Department of Labor, under an OMB directive, is requesting only a one-year extension of Title V at current levels. If the current services level is not maintained, some enrollees will lose jobs and be forced to rely on the income maintenance programs which are threatened by budget cuts. There will be no social welfare program to pick up the slack created by the loss of Title V jobs. Former enrollees will not even be eligible for SSI since Administration proposals are calling for retrospective accounting as a means to determine eligibility.

There are also other ways that money can be saved in fiscal year 1982 and beyond without reducing benefits to poor people. Here are a few suggestions:

Reduce the administrative costs of social welfare programs:

Review eligibility and reporting requirements and eliminate those which do not serve useful purposes. For example, instead of having itemized deductions from income to determine eligibility, use a standardized deduction as is done in the Food Stamp Program. This streamlining would eliminate administrative expense without sacrificing the benefits to the poor.

Eliminate the asset test in Supplemental Security Income (SSI) where the cost of administration probably exceeds the savings to the program. SSI recipients are generally those who have no work history and who have had bad luck throughout their lives and no opportunity to save at all. If this were not true, they would be getting most of their income from Social Security and other sources, not from SSI—a program of last resort!

Reevaluate the size of the proposed tax cut: We may not be able to afford to reduce taxes to the extent discussed in current proposals.

In closing, I would like to say that the National Council of Senior Citizens is sincerely committed to the goal that one day no American, regardless of age or income, will have to live with his or her basic needs unmet or basic rights denied.

We have carefully examined the budget propoals with this goal in mind. We have concluded that the proposed budget's treatment of dependent Americans will push this goal even further out of reach than it is today.

The CHAIRMAN. Mr. Marion Smith, chairman of the Governmental Affairs Committee, National Association for Retarded Citizens.

STATEMENT OF MARION SMITH, GOVERNMENTAL AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR RETARDED CITIZENS, ACCOMPANIED BY MYRL WEINBERG, GOVERNMENTAL AFFAIRS OFFICE

Mr. SMITH. Mr. Chairman, Senator Moynihan, I am a volunteer from Clearwater, Fla., speaking to you today for the eight organizations listed on the first page of our testimony, representing over 2,000 chapters of our organizations in all of the States.

I would like to add that I am a parent of a severly retarded child. Therefore, I have consumer experience both in community care and in the institutional realities in our land.

Senator Dole, as past president of our national organization, I recall very clearly your very excellent address to our national convention in Denver some 8 years ago. We appreciated that message and your work to bring the food stamp action through last year.

In the interest of time, of the committee's time today, I will summarize verbally the four key points of our written testimony, which, I believe, you have before you.

My first, of the four points, deals with the proposed action on block grants. We submit to you that there is a considerable and severe impact, financially speaking, on both State and local governments who must take up the slack of the 25-percent cutback and related dollars which will no longer be available.

It is clear to us, from our national overview, that my State government and yours are poorly prepared to take up this slack and, therefore, needed programs now will either have very restrictive requirements or will be eliminated in their entirety.

We see that the block grant proposal, as recommended, would increase the cost of services to disabled persons, because, as I will point out, the limitation on availability of needed health services to those who are now disabled may increase the extent or severity of their disability and result in both short and long-term increased cost to our Nation.

We think that the proposal, which states that services would be provided by the States is not well founded. As noted on page 2 of our statement, we submit that many of the Federal services now provided through categorical grants were not provided in the past, and we have no confidence that in many of the States many of the programs will be picked up in the future.

For example, the justice standing bill, which our organization supported last year, was brought about by the necessity to bring in the Justice Department with the right to intervene in cases of abuse of institutionalized persons.

The action being proposed now to assist in zoning—removal of zoning impediments in States and localities is an action very unlikely to be taken at the local level.

We note on page 4 of our testimony that the block grant proposal reductions will very likely result in a significant reduction in community care and service funds for disabled people. A transition has been taking place in America up to this point, that is, the shift of persons who are needlessly in institutions to more normalized lives in the community. However, with the States budgets alined behind institutions, and with the difficulty in finding new funds to provide community care and services, we see a very real danger of a reversion to more than 20 years ago and a reinstitutionalization of disabled people.

Disabled persons for whom we speak cannot fight back. We ask that you join us in being their champion. They are not letter writers. You haven't received many letters from persons in this category, and so we are here to speak for them today.

Our second point: In the medicaid arena, we note on page 5 of our testimony that some 77 percent, Senators, or 18 of the 23 million people eligible for medicaid are dependent children or aged, blind or disabled adults.

We feel that the arbitrary limit on Federal expenditures under medicaid rips the social safety net which we understand was not to be removed. The cap endangers, to a very great extent, the program of intermediate care facilities for mentally retarded persons and emphasizes our concern that reinstitutionalization may occur since funding may not be available for the ICFMR program.

Indeed, the absence or the threat of removal of Federal regulations, or softening of these, to me, from direct experience, poses a real danger because we have seen that the regulations to date have not been enforced. Unwarranted extensions have been requested, life safety codes are not present—may I continue, sir?

The CHAIRMAN. Another minute or two.

Mr. SMITH. I will summarize briefly. My third point: On social security disability insurance—we see this as a disaster for the younger disabled person. A key sample is on page 7, that is, the recency of work test requiring employment for 6 of the last 12 quarters. This should remain at the present test of 20 of the last 40 quarters.

Disabled people may have erratic work patterns because of their disabilities. A pregnant woman who had contributed into the fund, Senator, for 10 years, and then left work in the 6th month of her pregnancy, stayed home for a year and a half, and then became disabled would get no return from the 10 years she put into the program. We feel this is totally unfair.

Secretary Schweiker talked, I believe, to this committee and said if the administration's proposals are harmful, it would look at alternatives. We believe this is a key example.

And, finally, my fourth area, medicare, there are two issues relating to cost-effectivity. The Reconciliation Act of 1980 provided that outpatient providers under part B could be funded. This is a cost-effective action that the last Congress took. It is dollar foolishness to eliminate that provision and require persons to go to inpatient services instead of the less costly outpatient services.

And, finally, on page 11 we note that home health services provisions, under that act, should be continued for the same cost-effective reasons.

One quick example, Senator. In Clearwater, where we are training mentally retarded people to be office cleaning service nightime workers, the owner, Senator, of the local cleaning service came to us and said, "I'll take all your graduates for the next 3 years because they are dependable workers and if you can train them, I'll take all you can supply me for the next 3 years."

So, we submit to the committee that this illustrates that these persons can be taxpayers and not tax burdens, and we ask you to join us in being their champion.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, we have heard capable and important testimony. I would like to thank Mr. Smith for this. It confirms what I have felt to be the case that the 25-percent cutback in health and social services, combined with medicaid cap,

have a severe impact on the availability of community care for the mentally retarded.

And the point, Mr. Chairman, that there has been an enormous social movement in America to get people out of asylums, as they were called, and it is a movement comparable to the onset of the public schools. I think it involves you people and it involves people everywhere in communities who sense that there is something—a better way to do this, and we have been working on it, and we've been having success, and now it looks like we are going to be losing it all.

I have faith, and I think I sometimes bore this committee—sometimes I get the impression that this committee thinks I'm thinking about the State of New York more than one should, but the fact is that most of social services the Federal Government provides today, the State of New York used to provide on its own, the adoption services, we've had them for 15 years.

One way or another we will try to keep up our levels, but there are many parts of the country that won't. As you said, sir, had none of these services until the Federal Government came along to fund them, and, in some cases, even required them.

Mr. SMITH. Yes.

Senator MOYNIHAN. You make the point, and I end where I began, the children are the people, and there is nobody here—a lot of the people who should be here, aren't here. It is a scam the organizations that present themselves being concerned about the poor who are not present, but are here at all of our hearings, but you are, and others have been, of course. But 45 percent, you say, of the persons receiving medicaid are dependent children and we are interested, as I said earlier, weren't you struck by these figures that we developed, and they certainly struck us.

Before reaching the age 18, a third of the children in the United States will be on public assistance.

Mr. SMITH. Yes.

Senator MOYNIHAN. Well, then if we start tampering with that, is to start tampering with our children, our population, not a subgroup.

I hope you will help us, sir. I mean, the people who have made these proposals haven't done so out of animosity against your purposes, but I think they—there is, as yet, a lack of awareness of much would happen and could happen to people—to people very helpless, who are being helped.

I thank you, that is all I can say, and you are not forgotten in this committee and the chairman has to make the case he's made and he does it well, but you know that he is a person who cares a very great deal.

Mr. SMITH. Thank you very much.

The CHAIRMAN. Well, thank you, Mr. Smith, I can't quarrel with the statements—I wouldn't quarrel with the statements that were made by my colleague from New York.

Many of us have voted for and supported these programs and now they are up against the wall. I think that is the problem. It is not that we will want to do anything that has been suggested. I think we could make a case, as you have, for every single program

be spared reducton, but I have got to say, in all honesty, that some will not be spared; some may be spared.

You didn't give me a priority list, but it might be helpful. You know, if some have to go, I assume there are others——

Mr. SMITH. Yes.

The CHAIRMAN [continuing]. I don't ask you to do that now. It might not be fair, you represent so many different groups. You have as many constituents as we have. It makes it difficult when you start trying to single out this group over that group, but we will do the best we can, and we appreciate your testimony.

Mr. SMITH. We could submit a few recommendations—some recommendations for modification, which might be effective.

The CHAIRMAN. That would be helpful. If I take the President at his word, if we don't like what he has suggested, if we can find alternatives that still meet the general goals, we're not here to rubber stamp any President. I haven't known any Congress to do that. This Congress is no different.

Mr. SMITH. Thank you, sir. We will submit a followup statement with some recommendations.

The CHAIRMAN. Thank you.

[Statement follows:]

STATEMENT OF MR. MARION P. SMITH, CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE ASSOCIATION FOR RETARDED CITIZENS

TESTIMONY ON FISCAL YEAR 1982 PROPOSED BUDGET FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Disability organizations recognize the need for fiscal restraint and reduced federal spending. Given the current economic dilemma, allowing disabled people to become tax payers instead of tax burdens clearly should be a very high priority. Yet, the new Administration seeks to reduce or eliminate funding for the very programs which make this goal possible for do many disabled people. We are frankly puzzled by this short-sighted policy. A summary of our testimony is as follows:

1. The disability organizations represented by this testimony reject the Reagan Administration Block Grant proposals. The withdrawal of educational, rehabilitation, housing, health, social and other services would significantly enhance the likelihood of additional, much more costly, lifelong services for disabled people. Without federal programs, quality control mechanisms and funding, experience had shown that many disabled persons are inappropriately served or underserved and forced to lead unproductive lives in unsafe, even dangerous, living conditions, frequently in the confines of an institution (pages 1-4).

2. Our organizations strongly oppose the Administration's proposal to impose and arbitrary limit on federal expenditures under Medicaid. Medicaid is an essential component of our country's "social safety net." Without the basic health services funded through Medicaid many disabled persons will unnecessarily lead lives of dependency often becoming more severely disabled, will be unable to enter the workforce and will be inappropriately institutionalized (pages 5 and 6).

3. A change in the recency-of-work test for the Social Security Disability Insurance program to six out of the last twelve quarters, in our opinion, would be among the worst forms of discrimination against disabled people. It represents a total misunderstanding of the life experiences of the disabled population (pages 6-8).

4. Our organizations also oppose recalculating the Consumer Price Index and other similar proposals which would have the effect of establishing a continued erosion of the Disability Insurance benefit levels. We believe all methods which have been proposed to date will fail to take account of the real inflationary costs of items and services especially needed by disabled citizens (page 9).

5. We support Section 933 of the Reconciliation Act of 1980, P.L. 96-499, which recognizes outpatient rehabilitation facilities as providers under Medicare. We are opposed to the repeal of this provision as called for in the Reagan Administration's budget for fiscal year 1982. Section 933 does not add new benefits to Medicare but simply authorizes certain benefits to be provided in another setting—a setting which is less costly than hospital care. We also oppose the repeal of the home health

provisions contained in P.L. 96-499. These provisions will result in a more responsive home health system for disabled people, which will help to avoid more costly service delivery mechanisms (pages 9-12).

Mr. Chairman and distinguished members of the Finance Committee, I am pleased to have this opportunity to speak to you today on behalf of the eight organizations listed on the front page of our testimony. As will be demonstrated throughout the body of this statement our organizations maintain a keen interest in a number of federal programs including Medicaid, Medicare, Social Security, Community Mental Health Centers, and Vocational Rehabilitation. We believe that all of these programs serve many of the unmet needs of handicapped children and adults. Yet, in light of the President's fiscal year 1982 budget, all are at risk of serious funding cutbacks, limited elgibility and program access, or total repeal.

BLOCK GRANT PROPOSALS

President Reagan's "America's New Beginning: A Program for Economic Recovery" calls for a wholesale and indiscriminate consolidation of federal social programs. Though the plan, if enacted, might save the federal government money in the short run, it does not address either the fiscal impact on state and local government nor the impact on the lives of persons with disabilities whose quality of life depends on these benefits and services.

Before your Committee wholeheartedly endorses President Reagan's proposals, we ask you to document answers to the following questions:

(1) Where has a block grant/umbrella agency experience resulted in improved services to persons in greatest need?

(2) Can you ensure/guarantee to persons with severe disabilities that the benefits and services they now depend upon will continue under a block grant/umbrella agency approach?

(3) Can you ensure/guarantee that a block grant/umbrella agency approach will not result in an end to deinstitutionalization and start the reinstitutionalization of people with disabilities?

We ask you, cannot the cost and burdens of government be reduced without the total elimination of federal programs targeted on persons in need, such as those with severe disabilities? Are you willing to gamble with the lives of persons with severe disabilities because of the current drive to balance the federal budget?

Although our organizations clearly recognize the need to solve the economic ills of our nation, we cannot understand how the Administration expects to succeed by abolishing its commitment to programs and services for disabled persons. Someone must realize that the withdrawal of educational, rehabilitation, housing, health, social and other services will significantly enhance the likelihood of additional, much more costly, lifelong services for these people. The effects on future Federal budgets will surely be negative, to say nothing of the impact on the lives of the disabled individuals and their families.

Our organizations strongly reject the Reagan Administration Block Grant proposals. President Reagan talks of returning programs or the responsibilities to the states. This line of argument is inaccurate and deceiving since the states never had many of the programs or never assumed the responsibilities in the first place. Many of the categorical programs earmarked for consolidation into block grant programs were created precisely because the states were not providing the services the grant programs pay for, and more importantly they did not intend to provide those services. As a result, the national government, in bipartisan efforts which included the Executive Branch and Congress, created programs to provide services that were not being provided in the states.

We believe that without many of the categorical programs now being considered for consolidation the health and well-being of the disabled population will be at risk and, I might add, at considerable cost to the Federal government.

Let me give you one example. A 25% cutback in health and social services combined with the proposed cap on the Medicaid program can be expected to have a severe impact on the availability of community care for the mentally retarded, the mentally ill and other disabled populations frequently served in large institutional settings. The very real possibility exists that we are going to see extensive reductions in community care, while institutional services must still be paid for. Even as the community care movement has progressed over the last twenty years, state institution budgets have also increased despite the great reductions in the number of institutional clients. This clearly shows that state funding patterns foretell a retrenchment in community care if drastic federal cuts are made in community service programs. This trend will be unintentionally strengthened because public and private third party payments emphasize institutional care and because there remains a substantial stigma on disabled people. Many communities still object to

having disabled persons, especially mentally disabled individuals, living near them. Thus, there will be economic, political and public pressure to return these people to the institutions.

States and localities are clearly not in any condition, economically, to pick up the slack if the Federal government's commitment is so suddenly and dramatically reduced. Yet, ironically, costs to society as a whole increase when insitutional care is substituted for community care. Costs accrue to the unemployment system, public assistance and welfare, criminal justice system and the general health system. We fear that the economic models used by the Administration may not have accounted for these future costs to the federal government. Furthermore, affected Americans have not had an adequate opportunity to express their concerns about these issues.

With major program consolidation through block grant to states, increasing numbers of vulnerable people will be pitted against one another in competition for the same, limited resources. One group of vulnerable and needy people will expend their energies and attention fighting with other groups of vulnerable and needy people.

Experience with the Title XX Social Services, housing and other noncategorical programs has demonstrated that disabled people and their organizations often are not equipped to compete for scarce funds and services at the state and local level. Other, more powerful groups with larger voting constituencies have been able to garner the lion's share of funds and program activity under these programs. If disabled people are faced with the necessity of fighting over large block grant funds, it is very likely that they will not emerge victors.

MEDICAID

Our organization stongly oppose the Administration's proposal to impose an arbitrary limit on federal expenditures under Medicaid. President Reagan has said he will not cut "social safety net" programs. The Medicaid program is an essential component of our country's "social safety net." More than eighteen million of the twenty-three million people eligible for Medicaid are dependent children or aged, blind or disabled adults. Forty-five percent of all Medicaid eligible individuals are children.

A quickly enacted cap will not result in long-term "real" cost savings. It will merely shift costs to state and local governments which will be forced to either absorb the increased costs or deny eligiblity and services. The corresponding reduction in preventive and primary care services will produce greater health problems and higher costs later on.

Without the basic services funded through Medicaid many disabled people will become more severely disabled. Many children will lead lives of almost total dependency—unnecessarily. Disabled persons who are working or have the potential to work will no longer be able to afford to work and the Federal government will lose their contributions as productive employees.

Cutbacks in the Medicaid program would play a primary role in the process of reinstitutionalizing many disabled persons. The Medicaid program, through the Intermediate Care Facilities for the Mentally Retarded program, finances state-operated institutions and small community residences for mentally retarded and certain other developmentally disabled persons. This ICF/MR program is optional. Given states' ongoing financial obligations to the operations of state institutions—large mortgages, bond debts, increased capital expenditures required to meet the life safety code for Medicaid certification—it is likely that some state will choose to curtail, if not altogether, halt, the development of small community living arrangements.

I would like to make one additional point relative to the ICF/MR program. Along with the cap on Medicaid, President Reagan is proposing, wherever possible, the elimination of regulations in order to reduce administrative costs for the programs and to provide the states more flexibility in program administration. This may very well mean the elimination of all or most of the minimum staffing standards, life safety code requirements and other quality control regulations for the ICF/MR program. Combined with the known lack of enforcement at both the state and federal level, this elimination of critical governing regulations may lead to unsafe, even dangerous, living conditions for mentally retarded individuals.

SOCIAL SECURITY DISABILITY INSURANCE

The financial stability of the Social Security trust funds has been a nagging problem for Congress and the various Administrations since 1975. Actuarial estimates have been given, legislative "remedies" passed, and revised estimates provided ever since passage of the 1977 Social Security financing amendments. Throughout this process, Social Security disability insurance recipients have borne

the brunt of efforts both to restore fiscal balance to the system and to slow the growth in demands upon the social security program. The Social Security amendments of 1980 (P.L. 96-265) placed a "cap" on maximum family benefits for DI beneficiaries and reduced the number of dropout years allowed for younger workers. The Association for Retarded Citizens opposed these cuts which were, in our opinion, based on faulty assumptions. Now, much to our dismay, we see some of these same assumptions operating as the basis for additional changes to the Disability Insurance program.

Let me first address the President's proposal to change the "recency-of-work" test by requiring disability insurance beneficiaries to have worked one and one-half of the three years (or six out of the last twelve quarters) preceding disability in order to be eligible for the DI benefits which replace lost wages.

While it may not have been intended, this proposal, if it became law, would be among the worst forms of discrimination against the disabled. It represents a total misunderstanding of the life experiences of disabled persons. For example, many mentally retarded people, many of whom have physically handicapping conditions, have fluctuating work histories depending on their abilities, employers' attitudes, the rate of unemployment, etc. If at the time they needed to apply for DI benefits they had not worked one and a half out of the last three years, they would be denied coverage under the Social Security Disability Insurance program even though they had contributed to the system in earlier years.

Two other examples will help illustrate the potential impact of the Reagan proposal. Under the proposed "recency-of-work" test, a woman who left the workforce temporarily, after ten straight years of contributing to Social Security, during her sixth month of pregnancy and spent one and a half years totally dedicated to child rearing, and then became disabled by a disease or trauma, would not be eligilble for benefits. Likewise, persons with types of disabilities which exacerbate and remit in unpredictable patterns including arthritis, forms of cancer, multiple sclerosis, some types of mental illness, etc., would be faced with new disincentives to returning to work. Many would be caught in the trap of quarters-counting and betting on the odds of whether they will be able to work for the next several quarters.

The complications of life activities for persons with disabilities suggests that a recency-of-work test of such short duration would not be fair to those who have contributed substantially in previous years. We intensely favor retaining the present eligibility requirements with respect to fully insured status. Current law requires beneficiaries to have worked five out of the last ten years (or twenty out of the last forty quarters). We were glad to hear HHS Secretary Schweiker say before your Committee on March 17 that if the proposed change in the recency-of-work test would be harmful to persons with disabilities, especially those with degenerative diseases, the Administration would be more than willing to look at alternatives. We believe the proposed change would be extremely harmful and ask you to look for alternative ways to save money in order to stabilize the Social Security system.

Various proposals which have emerged during discussions of ways to help the financial problems of the system would have the effect of establishing a continual erosion of benefit levels. Less than 100% of CPI increases, the lesser of wage or price increases, and other adjustments which would over a period of years reduce the benefit levels in real dollar terms, assume that benefit levels for the vast majority of DI recipients and their families are overly generous. We do not believe that to be the case. Likewise, recalculating the CPI is not something we can support; we believe all those methods which have been proposed so far will fail to take account of the real inflationary costs of items and services especially needed by disabled citizens. Any fair analysis of the resources available to disabled individuals and families receiving DI as compared to other citizens would demonstrate the extreme financial restraints under which most disabled persons and their families live.

MEDICARE

In our testimony today we would like to address only two issues relative to the Medicare program.

Late last year, the Congress passed and President Carter signed the Reconciliation Act of 1980, P.L. 96-499. Section 933 of that Act recognizes outpatient rehabilitation facilities as providers under Medicare. The provision is effective on July 1, 1981. The effect of this provision is to make all of the services which these facilities provide, including physical therapy, occupational therapy, speech pathology services and respiratory therapy, reimbursable under Part B of the program.

The Reagan Administration's budget for fiscal year 1982 proposes repeal of this provision (and many other Medicare provisions which were contained in the Recon-

ciliation Act). We are opposed to the repeal of this provision and believe that President Reagan's position ignores the need for less costly ambulatory alternatives to hospital care.

Since the beginning of the Medicare program, all of these services have been covered under Part B when provided by hospitals, either on an inpatient or an outpatient basis. However, freestanding outpatient rehabilitation centers could receive Part B reimbursement only for physical and speech therapy services. This policy promoted the use of hospital-based services, despite the fact that the services provided by freestanding centers are less costly and frequently more accessible than those provided by hospitals.

In the Reconciliation Act, the Congress acted to rectify this problem by allowing reimbursement under Part B for all comprehensive outpatient rehabilitation services, whether provided by a freestanding outpatient center or by a hospital. Section 933 does not add new benefits to Medicare but simply authorizes those benefits to be provided in another setting.

The provision in question was first proposed in the late 1960's. During several previous Congresses, it was included in legislation which was approved by one House but not the other. In 1978, for example, it passed the House almost unanimously as part of H.R. 13097, the Medicare Amendments of 1978, but died in the Senate because of the lateness of House passage. Enactment by the 96th Congress concluded a ten-year effort by various national organizations, most notably the National Easter Seal Society, the National Association of Rehabilitation Facilities, the American Occupational Therapy Association and the American Association for Respiratory Therapy. Furthermore, the language of Section 933 was worked out over considerable time with a large number of people in the rehabilitation community to insure that the covered services were sufficiently defined and subject to adequate quality controls.

When Section 933 is implemented, many of your constituents will have greater access to these benefits. In many cases, individuals who are being treated in a hospital will be able to receive these medical services in a freestanding outpatient clinic at a lower cost to the Medicare Trust Fund.

The Reconciliation Act also changes the home health provisions under Medicare. It provides Medicare coverage for unlimited home health visits; eliminates the three-day prior hospital stay requirement under Part A of Medicare; eliminates the $60 deductible for home health benefits under Part B; and includes several other provisions aimed at improving home health benefits and the delivery and administration of such benefits. Each of these provisions will result in a more responsive home health system for disabled persons. Unfortunately, President Reagan also proposes to repeal all the home health provisions in P.L. 96-499.

We urge you to oppose any efforts to repeal the home health provisions or Section 933 of the Reconciliation Act of 1980.

In closing, let us again reiterate our recognition of the need for fiscal restraint and reduced federal spending. However, we also recognize the ongoing needs of persons with disabilities and we accept the need for federal assistance to these persons.

Given our current economic dilemma, allowing disabled people to become tax payers instead of tax burdens clearly should be a very high priority. Yet, the new Administration seeks to reduce or eliminate funding for the very programs which make this goal possible for so many disabled people. We are frankly puzzled by this short-sighted policy! In our zeal to straighten out our economy, we must carefully assess the implications on the future. Caution must be exercised to insure that the lives, freedom and independence of millions of people are not destroyed or disregarded.

Disabled people and those representing them are deeply concerned that the total level of support for primary programs that benefit them will be reduced and that backup and support programs will also be reduced or eliminated. When taken in their entirety, the cumulative effects of President Reagan's proposals spell disaster for the disabled population in our country.

Your thoughtfulness regarding the complexity of these issues is appreciated.

The CHAIRMAN. Our final witness is Fred Barrett, chairman, Unemployment Insurance Commission of the Interstate Conference of Employment Security Agencies, Inc.; administrator, Employment Security Division, State of Montana.

If Senator Baucus arrives, he may want to add to your introduction.

In the meantime, you may proceed.

TESTIMONY OF FRED BARRETT, CHAIRMAN, UNEMPLOYMENT INSURANCE COMMITTEE OF THE INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES, INC., ADMINISTRATOR, EMPLOYMENT SECURITY DIVISION, STATE OF MONTANA

Mr. BARRETT. Thank you, Senator, Mr. Chairman and members of the committee.

The Interstate Conference of Employment Security Agencies is composed of the 53 State administrators involved in the administration of the unemployment insurance program and job service operations.

We strongly support the unique Federal/State arrangement and partnership in the employment security system, and, accordingly, oppose Federal standards which limit the State's ability to operate these programs efficiently and to tailor programs specifically to local and State needs.

My views today will be in four different areas. First, the modifications of the extended benefit program, which provides benefits to workers who have exhausted their regular benefits during periods of higher than normal unemployment.

Second, the modification of the regular unemployment insurance program requiring claimants who have collected 13 weeks of benefits to accept available work which meets certain minimum requirements.

Third, the modification of unemployment insurance benefits for ex-military personnel, and, finally, modifications to the worker trade adjustment assistance program.

On the first area under consideration, modification of the extended benefit program, we support these proposals in the large part. We support the elimination of the national trigger, which at present requires many States to pay benefits despite local or statewide excellent economic conditions.

We also believe that States should be allowed to set the optional State trigger higher than the current 5-percent level.

Our membership has not established a specific position on the trigger change from 4 to 5 percent, plus the existing 20-percent increase from the prior 2 years. We do believe, however, that the States would welcome this on an optional basis.

Third, we support the exclusion of extended benefit claims from the calculation of the trigger rates. Including extended benefit claims results in a different definition of high unemployment for purposes of triggering "off" extended benefits than was in effect for triggering "on" and creates inequities among the States.

The final proposal concerning extended benefits is a requirement for 20 weeks of work in the base period as a qualifying criterion.

The additional weeks of benefits are justified by high unemployment levels, and if the individual qualified for regular benefits, we feel that he should also qualify for extended benefits.

Going into another area, we strongly oppose the proposal requiring claimants who have drawn unemployment insurance benefits for 13 weeks to accept available work at certain minimum standards.

This proposal, apart from appearing contrary to the administration's stated intention to return responsibilities to the States,

would be a significant departure from the principles which have governed the unemployment insurance system for the last 40 years.

Each State currently defines suitable work in a way which reflects its own labor market conditions, the views of the employers who finance the program, and the needs of unemployed workers.

We strongly urge you to reject this proposal.

Next, we have some questions regarding the third area under consideration, that is, the elimination of unemployment insurance benefits for those who have completed their term of voluntary enlistment and choose not to re-enlist for military service. It is not clear to us whether this means that the ex-servicemembers military wage credits would be arbitrarily canceled by failure to reenlist, and whether there is any determination of good cause for voluntarily leaving the military.

We believe that this proposal should be examined more closely and the treatment of former military personnel compared to that of workers in the private sector who voluntarily leave employment.

Our membership has not established positions concerning the specific changes in the trade adjustment programs, which have been proposed by the administration. We do believe, however, that any special assistance provided for permanently displaced workers should be determined by the potential benefit to the individual and the economy rather than solely by reason for the worker's unemployment.

Lastly, Mr. Chairman, we would like to emphasize two points that are mentioned in passing that we feel should be considered in connection with any unemployment proposals which come before this committee.

First, any modifications made to the State or extended benefit programs will require the 53 jurisdictions to enact their individual laws to conform to the Federal legislation.

We urge you to allow sufficient time for State legislatures to act. The imposition of heavy penalties on a State—a tax penalty on State employers—simply because the State did not have time enough to act would certainly be unfair.

Second, the Interstate Conference understands that recommendations to modify and reduce benefit outlays in the regular benefit program are very attractive to the Congress, especially now when the Nation faces substantial pressures to balance the Federal budget.

However, we would emphasize the point which was made earlier by another witness regarding the social security program, that the inclusion of State unemployment insurance trust funds in the Federal unified budget, accomplished through Executive order, creates an artificial sense of fund availability.

State unemployment insurance trust funds financed entirely through each State's employer taxes are dedicated solely to the payment of regular unemployment insurance benefits to qualified workers in each State.

State trust funds cannot be utilized for any other purpose or be borrowed by the Federal Government or State governments. Therefore, we urgently request that the committee reaffirm basic principles of the Federal-State partnership by rejecting proposals which

disrupt the integrity of the regular unemployment insurance system in each State.

We certainly appreciate this opportunity to have our views before the committee. I have presented to the committee a full statement which we would request be included in the record.

The CHAIRMAN. It will be made a part of the record.

Mr. BARRETT. Thank you, sir, and we would be glad to answer questions now or in writing that the committee members might have.

The CHAIRMAN. I would just say that I appreciate very much your excellent statement, which is made a part of the record.

[Statement follows:]

STATEMENT BY FRED E. BARRETT, ADMINISTRATOR, MONTANA EMPLOYMENT SECURITY DIVISION AND UNEMPLOYMENT INSURANCE COMMITTEE CHAIRMAN OF THE INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES

SUMMARY

The Interstate Conference of Employment Security Agencies (ICESA) is an organization of all 53 state administrators responsible for unemployment insurance and job service operations. We strongly support the unique federal-state partnership in the employment security system, and accordingly oppose federal standards which limit the states' ability to tailor programs to local needs. Outlined below are our positions, determined by a majority vote of the members, concerning the administration's spending reduction proposals in unemployment benefits.

1. Extended benefits.—(a) We support elimination of the national trigger, which at present requires many states with excellent economic conditions to pay additional weeks of benefits; (b) We support the exclusion of EB claims from the calculation of trigger rates. Including EB claims results in inequities among states; (c) We also believe that states should be allowed to set the optional state trigger higher than the current 5 percent level. Out membership has not established a position regarding the increase in the required state trigger from 4 to 5 percent (plus a 20 percent increase from the prior 2 years). We do believe, however, that states would welcome this on an optional basis; (d) We strongly oppose a federal standard for 20 weeks-of-work in the base period to qualify for EB. Benefit qualifying requirements should be determined by each state to meet individual state needs.

2. Federal suitable work requirement after 13 weeks of benefits.—We strongly oppose this significant departure from the principles by which the unemployment insurance system has served us well for over forty years. Every state currently defines suitable work in a way which reflects its labor market conditions, the views of employers who finance the program, and the needs of unemployed workers in the state.

3. Denial of benefits to those who voluntarily leave the military.—We believe that this proposal should be examined carefully and its treatment of former military personnel compared with that of workers in the private sector.

In conclusion, we would like to emphasize two points. First, any modifications to the state or extended benefit programs will require conforming state legislation. We urge you to allow sufficient time for state legislatures to act. Second, while state trust fund monies are included in the federal unified budget, those funds are state employer taxes and are dedicated solely to the payment of unemployment benefits to qualified workers in each state. A reduction in benefit outlays will not free funds for any other purpose.

Mr. Chairman, Committee members, my name is Fred E. Barrett. I am Administrator of the Montana Employment Security Division and Unemployment Insurance Committee Chairman of the Interstate Conference of Employment Security Agencies. We welcome the opportunity to come before you today and present our views on the several proposals for reducing costs related to the unemployment insurance program.

The Interstate Conference of Employment Security Agencies (ICESA) is an organization whose members include the state administrators from the fifty states, Puerto Rico, the Virigin Islands and the District of Columbia. As the individuals responsible for administering the unemployment insurance program, the Employment Service as well as other employment and training programs in the states and jurisdictions, we are dedicated to the continued review and improvement of the programs

we operate. The positions we will present to you today represent those approved by a majority vote of our membership, unless otherwise indicated.

As a beginning point, the Interstate Conference always encourages reviews of the unemployment insurance program which are intended to improve its quality and services to the unemployed, while insuring its costs are reasonable and fairly distributed. We are reminded, when reviewing measures which will change the program that the balance between the state and federal governments in creating and administering the unemployment insurance system is unique in all the many arrangements that exists in our nation. The Interstate Conference is convinced that it is the very uniqueness of the federal-state partnership which has given the unemployment insurance system its strength to withstand the demands that it has faced for the past 45 years. At the same time, the nature of the partnership requires careful consideration of the federally mandated changes in the program which will then have to be enacted by the 53 states and jurisdictions. The original notion that the states must each knowledgeably review their own special labor market configurations and enact unemployment compensation laws, within broad federal guidelines, which best serve the unemployed workers and the employers in that labor market, still must be considered by each of us when recommending modifications to the unemployment insurance system. It is in light of the special relationships between the states, the Congress, and the federal executive branch that we present our views to the Committee.

MODIFICATIONS TO THE EXTENDED BENEFITS PROGRAM

The first group of proposals we will address are those involving modifications to the extended benefits program which provides payments to workers who have exhausted their regular unemployment insurance benefits during periods of higher than normal unemployment. The Interstate Conference supports continuation of the extended benefits program but believes that some improvements can be made. We believe that eliminating the national trigger and allowing states to set the optional state trigger higher than five percent will target extended benefit payments to locations where they are most needed. We also favor the exclusion of extended benefit claims from the calculations which determine the beginning and ending of extended benefit periods. We oppose the establishment of a federal requirement for 20 weeks of employment in the base period in order to qualify for extended benefits, believing that benefit qualifying requirements are best left to the states.

Our members believe that the sound and efficient administration of a federal-state partnership requires the states to share equally in the responsibility for decisions which directly affect the costs of the program. In the case of unemployment insurance benefits paid after the exhaustion of regulation benefits, the state is responsible for financing 50 percent of the costs and the federal partner is responsible for the remaining 50 percent of the costs of these benefits. Under current law, the national trigger requires many states to pay extended benefits when unemployment levels in that state do not warrant the continued payment of benefits beyond the regular 26 weeks. The elimination of the national trigger returns the responsibility and basis for determining the beginning of an extended benefit period to the state.

Another proposal for modifying the extended benefit trigger mechanisms would increase the required state trigger from four percent to five percent insured unemployment (the rate must also represent a twenty percent increase over the prior two years) and the optional state trigger rate from five percent to six percent. When Senator Boren proposed last year that the states be allowed to increase the optional state trigger level, a poll of our membership resulted in support for that concept.

Many states believe that the decision to define the level of the state extended benefit trigger should be made at the state level. Since the decision to raise the state's trigger level would occur through consultation with the state's employer, workers and citizens, and since the state is responsible for assuming the cost of 50 percent of extended benefits, the Interstate Conference believes it is important for the states to have the option of increasing the level at which extended benefits become available in each state. We would, therefore, urge the Committee to recommend that states be provided the option of raising the state's trigger levels, rather than making this mandatory change in the federal unemployment insurance law.

While there has been a great deal of confusion about the inclusion or exclusion of extended benefit claimants in the calculation of the extended benefit trigger, the ICESA Unemployment Insurance Committee makes the following observation and recommendation:

The inclusion of extended benefit claimants in calculating the EB trigger rates actually creates two definitions of high unemployment. One definition is for triggering "on" and one for triggering "off". In order to trigger "on" 4 percent of those

covered by unemployment insurance in a state must be collecting regular UI benefits, disregarding the number who may have already exhausted benefits. In order to trigger "off" there must be less than 4 percent collecting both regular and extended benefits. Because both types of claims are counted when triggering "off" less than 4 percent must be collecting regular benefits in order to offset those collecting extended benefits. Therefore, among several states with the same rate of unemployment based on regular claims, some may be paying extended benefits and others would not be. The UI Committee believes that the same populations should be used to calculate both the "on" and "off" triggers.

The recommendations of the ICESA Unemployment Insurance Committee reflect and earlier position adoption by the membership which supports the exclusion of extended benefit claimants from the calculation of triggers for beyond 39-week benefit programs. Therefore, the Interstate Conference concurs with the proposal to exclude extended benefit claims from the calculations for all program triggers.

The final proposal concerning extended benefits would establish a federal requirement of twenty weeks of employment in the base period in order to qualify. We oppose this and other federal qualifying requirements for both regular and extended benefits. States have developd many different measures of labor force attachment as qualifying requirements for UI benefits. Some use weeks of employment, others use various wage formulas. Even though the Administration's proposal is said to allow for a wage equivalent, this standard still preempts the state's ability to establish qualifying requirements which reflect the state's own labor market conditions. We would like to point out also that unemployed workers who meet only the minimum requirements generally qualify for a small amount of benefits for only a short period of time.

MODIFICATION TO THE REGULAR UNEMPLOYMENT INSURANCE PROGRAM

The second major proposal under consideration today would require claimants who have collected 13 weeks of benefits to accept available work which meets certain minimum requirements. Suitable jobs would be those that pay at least minimum wage or the equivalent of the claimant's weekly benefit amount, that meet basic health and safety requirements, and that meet other existing federal standards. As we understand this provision it is identical to one of the newly enacted requirements for the receipt of extended benefits contained in the Omnibus Reconciliation Act of 1980.

The Interstate Conference urges the Subcommittee to reject this proposal. A federal mandate defining suitable work in the regular state program would be a significant departure from the principles under which the federal-state unemployment insurance systen has served us well for over 40 years. This proposal also appears contrary to the Administration's stated intention to return responsibilities for programs to the states in order to better serve local needs.

As you know, the regular benefit programs are administered under state laws which both define the benefit qualifying requirements and the conditions under which they may be received. The states are responsible as well for financing the costs of these benefits. All state laws currently include requirements that claimants be available for and seeking suitable work during their benefit eligibility. Furthermore, each state has determined definitions of suitable work which reflect that state's labor market conditions, the views of the employers who finance the program, and the needs of the workers who benefit from the program.

Particulary in the regular benefits program, the theory of suitable work recognizes that each claimant has some skills which were utilized during the period of employment which qualified the individual to receive unemployment insurance benefits. States determine what is suitable work for an individual claimant based on his skills, past earnings, the local labor market conditions and the length of his spell of unemployment. States attempt to provide the claimant with guidance to jobs which will utilize his skills and which will pay wages similar to his last employment. This strategy means that claimants are encouraged to continue using the skills they have developed and have an opportunity to continue to earn the highest wages possible. When it becomes clear that a claimant will not be able to obtain employment commensurate with his or her last job, then energies are directed toward locating other types of suitable work, which may pay lower wages.

Automatic referrals to low and minimum wage jobs at the 13th week essentially short-circuits the state's opportunity to work with the claimant and to seek placement opportunities for individuals at the highest possible skill and wage level. The impact of this proposal on employers should also be considered. Many employers may not wish to receive referrals of individuals who are over-qualified for job openings. Employers who do hire over-qualified workers may find that these individual seek other job opportunities resulting in increased turnover for the employer.

Finally, we should consider the overall economic impact: When lower paying jobs are filled with higher skilled individuals, those with lower skilll levels are faced with fewer job opportunities and potentially must turn to welfare or other income maintenance programs for survival.

The Interstate Conference understands that recommendations to reduce benefit outlays in the regular benefit programs are very attractive to the Congress when the nation faces substantial pressures to balance the federal budget. However, we would only point out that the inclusion of state unemployment insurance trust funds in the federal unified budget, accomplished through Executive Order, creates an artificial sense of fund availability. The state unemployment insurance trust funds, financed entirely through each state's employer taxes, are dedicated solely to the payment of regular unemployment insurance benefits to qualified workers in each state. The state trust funds cannot be utilized for any other purposes or be borrowed from by the federal government or other states. Therefore, we urgently request that the Committee reaffirm the basic principles of the federal-state partnership by rejecting proposals which disrupt the integrity of the regular unemployment insurance programs in each state.

Additionally, as the Committee considers these proposals, we urge you to remember that any modifications made to the state or extended benefits programs will require 53 jurisdictions to enact conforming legislation. Effective dates for proposals requiring state authorizing legislation which are less than two years beyond the date of enactment for federal legislation do not provide states with sufficient time to secure state authorizing legislation. Several state legislatures meet only in alternate years. We hasten to remind the Committee that the penalty for failure to conform to federal laws results in an almost five-fold increase of the federal unemployment tax for employers in decertified states. The impositions of this heavy tax burden on a state's employers simply because the state did not have sufficient time to act would certainly be unfair.

MODIFICATION OF UNEMPLOYMENT INSURANCE BENEFITS FOR EX-MILITARY PERSONNEL

A third area under consideration today proposes the elimination of unemployment insurance benefits for military personnel who voluntarily leave the service. We understand this recommendation to mean that military personnel who fail to accept a reenlistment offer will be denied unemployment insurance benefits.

Basically, military personnel can be thought of as workers who are earning wages. If military personnel who fail to reenlist have earned sufficient wages to qualify for unemployment insurance benefits, denying those benefits arbitrarily eliminates their wage credits. The Interstate Conference has consistently opposed proposals which would either eliminate wage credits or remove a group of individuals from coverage. If the intention of this proposal is to eliminate wages earned as a member of the armed services from consideration for unemployment purposes when an individual fails to reenlist, the Interstate Conference would oppose this recommendation.

If the intent of this proposal is to treat failure to reenlist for military service as voluntarily leaving employment is treated in the private sector we would like to emphasize two points. First, all state laws recognize and define the notion of "good cause" for voluntarily leaving employment. Normally, good cause is defined in terms of the decision a reasonable and prudent person would make when faced with a particular employment situation. If good cause is established, benefits would be paid. Second, wages paid for employment which as individual leaves voluntarily may be used in determining his labor force attachment and qualification for benefits if he later becomes unemployed through no fault of his own.

The Interstate Conference recommends that the Committee consider the implications of the proposal to eliminate benefits to individuals who fail to reenlist. Should it become clear that this proposal amounts to an arbitrary elimination of wage credits for a class of workers, the Interstate Conference urges the Committee to reject this proposal. If the intent of the proposal is to consider voluntarily leaving the military as voluntarily quitting employment, then some other considerations may be required to determine if there are any situations which should be considered as good cause for not reenlisting. In either event, the Interstate Conference would be delighted to work with the Committee and its staff to explore possible options for clarifying the intent and direction of this recommendation.

MODIFICATIONS TO WORKER TRADE ADJUSTMENT ASSISTANCE

The state employment security agencies act as paymaster for trade adjustment assistance benefits to workers unemployed due to imports. While our membership has not established positions on the specific proposals of the Administration con-

cerning these benefits, ICESA's Unemployment Insurance Committee has made some comments concerning special worker protection programs. Those comments reflect the philosophy that these programs create inequities in the treatment of unemployed workers by providing more generous benefits for those covered by special programs than are available to other unemployed workers. We do recognize that skilled workers who are permanently displaced from their jobs need special assistance in making the transition to new careers. We believe that the assistance provided should be determined by a variety of factors including the potential benefits to the individual and the economy rather than solely by the reason for an individual's unemployment.

SUMMARY

In summary, the Interstate Conference concurs with the recommendations to eliminate the national extended benefit trigger and to exclude extended benefit claims from trigger calculations. We favor a provision which would permit states to increase the optional state trigger from 5 percent to 6 percent and believe that our members would support an optional increase in the required state trigger from 4 percent to 5 percent (plus a 20 percent increase in unemployment). We urgently request the Committee to reject the proposed federal standard requiring unemployed workers to accept any work meeting minimum requirements after 13 weeks of benefits. We ask you to carefully consider the implications of excluding ex-military personnel from unemployment compensation coverage. Finally, we ask that you consider both the equity of special worker protection benefits as well as the needs of displaced workers as you consider modifications to Trade Adjustment Assistance.

We remain fully available to work with the Committee and its staff to assist in developing improvements to the unemployment insurance program. I will be delighted to answer any questions that you may have for us, either in writing or at this time. Thank you very much for this opportunity to present our views.

The CHAIRMAN. I would yield to Senator Baucus for questions or comments. I told him that you were on the way.

Senator BAUCUS. Thank you, Mr. Chairman.

Fred, I want to thank you very much for coming.

Mr. Chairman, I might say that I have known Fred Barrett for some time, in fact, for all the years that I have been in public life.

Fred, frankly, has served our State of Montana years before that and if Fred, in my judgment, presents a viewpoint that States can handle a lot of these problems, that the States should be able to continue those traditional rights and generally handling unemployment compensation programs.

I strongly suggest that the committee listen to him very closely.

There is no reason for me to think that other States can't do as well and handle the area as well as Fred has, but, believe me, in my judgment, he has done so well that we would be well-advised here in Washington if we had administrators who handled, you know, Federal programs as well as he has handled ours in Montana.

There have been no problems in Montana, no scandals, no complaints, no criticisms over the years and I want to thank you, Fred, first, for the service you provided, but, second, for coming here to give us the benefit of your views, and particularly giving Washington the benefit of the views of somebody west of the Hudson River.

There is a bit of parochialism in this—part of this country, and certainly in this city, and it is helpful for you to come and help clear the air a little bit.

I want to thank you very much for coming.

Mr. BARRETT. Thank you, Senator, and for those kind remarks.

The CHAIRMAN. Well, I share that last view. I think as you look down the witness list, almost daily, you find most of the witnesses

are Washington, D.C. They are all great people, but many of them have never been out of the city and it is nice to have somebody come in. We've had somebody as far as Kansas today and, now, Montana out there where people still like to think for themselves and react for themselves and make their own judgments, and I think your statement reflected that.

I mean, you agree in some areas with the administration's proposals and you disagree with others, and that is certainly the way it should be.

We will probably have disagreements on this committee. Your suggestions will be most helpful.

Mr. BARRETT. Thank you, sir.

The CHAIRMAN. Any other questions?

Senator BAUCUS. No, thank you, Mr. Chairman.

The CHAIRMAN. If there are no other questions or no other witnesses, the full committee will recess until 9:30 on Tuesday.

There will be a subcommittee hearing tomorrow morning chaired by Senator Wallop on energy and on Monday, Senator Packwood at 9:30 will chair his Subcommittee on Taxation on a number of taxation annuities, taxation of private foundations, a number of other bills introduced by Members of the Congress.

Thank you very much for coming, and we will be in recess of the full committee until 9:30 Tuesday.

[Whereupon, at 12:20, the hearing was adjourned subject to the call of the Chair.]

SPENDING REDUCTION PROPOSALS

TUESDAY, MARCH 31, 1981

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 9:35 a.m., in room 2221, Dirksen Senate Office Building, Hon. Robert J. Dole (chairman of the committee) presiding.

Present: Senators Dole, Chafee, Heinz, Durenberger, Grassley, Long, Byrd, Baucus, and Bradley.

Senator DURENBERGER. The hearing will come to order.

I am pleased to welcome all of our witnesses today at what is the fifth day of public hearings on the administration's budget reduction proposals.

As many of you know, the focus of today's hearing will be on the medicaid program. Tomorrow's hearing will include testimony on the title V program and Thursday's witnesses will include Dave Stockman, Director of the Office of Management and Budget, and Governor Matheson from the State of Utah.

A lot of questions have been raised in response to the proposal to place a cap on Federal spending for the medicaid program. The questions include those regarding the impact on the elderly and the poor and those relating to the alternative proposals available to us as a substitute for the cap.

I have, like many of my colleagues, some very serious concerns that, in our legislative efforts to reduce Federal spending, we don't place individuals, particularly those who are poor or elderly at inordinate risk.

So I am hopeful that our witnesses today will provide us with their suggestions, now that they have all had 6 weeks or so to deal with our problem, as to how we might achieve our goal of controlling Federal spending and what they believe to be the benefits and the drawbacks of the administration's proposal in that regard.

I am also eager to hear comments on possible modifications of the medicare program, both long range and short range, so I thank you all for your willingness to be here today for any comments you would like to make.

Our first panel is stretching the definition of "panel"; it's two people, Mr. Paul M. Allen, director, Medical Services Administration, Michigan Department of Social Services, and chairman, State Medicaid Directors Association, Lansing, Mich.

Paul, welcome.

Mr. ALLEN. Good morning.

Senator DURENBERGER. And Gerald Reilly, who is deputy commissioner, New Jersey Department of Human Services, and chair-

man of the Health Care Committee of the National Council of State Public Welfare Administrators. Gerald is from Trenton, N.J.

We welcome you both.

Do you want to position yourself in the middle or wherever you are comfortable. Just make sure you have a mike.

Paul, are you going to start, or Gerald?

Mr. ALLEN. Gerry is going to start.

Mr. REILLY. I will start.

Senator DURENBERGER. Great.

Please go right ahead.

STATEMENTS OF PAUL M. ALLEN, DIRECTOR, MEDICAL SERVICES ADMINISTRATION, MICHIGAN DEPARTMENT OF SOCIAL SERVICES, CHAIRMAN, STATE MEDICAID DIRECTORS ASSOCIATION, LANSING MICH., AND GERALD REILLY, DEPUTY COMMISSIONER, NEW JERSEY DEPARTMENT OF HUMAN SERVICES, CHAIRMAN, HEALTH CARE COMMITTEE, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS, TRENTON, N.J.

Mr. REILLY. Mr. Chairman, Senator Long, we appreciate very much this opportunity to testify before you today.

I am Gerry Reilly, chairman of the Health Care Committee of the American Public Welfare Association and deputy commissioner of the New Jersey Department of Human Services.

In addition, I was director of our State medicaid program for 2 years.

I intend to briefly outline some views of State human service commissioners who are directly responsible for managing the medicaid program at the State level.

Mr. colleague, Paul Allen, is vice chairman of the health care committee and is chairman of the State Medicaid Directors Association. Paul is going to describe some of our specific proposals for program inprovement.

The States have an enormous stake in medicaid cost containment. We will pay $12.9 billion, or 44 percent of the cost, in the current fiscal year. Therefore, we strongly support efforts to restrain costs in the health care sector.

Such efforts, however, must not be restricted to medicaid alone, but must include, in a balanced way, medicare and other federally financed health care programs.

Efforts restricted to medicaid will not be effective and will lead to an erosion of health care access to the poor and to many elderly people.

The administration's proposed 5-percent cap for fiscal year 1982, with a GNP deflator index to govern the growth of the program thereafter, raises several important questions.

Will differences in State management efforts to date be taken into account?

Will provisions be made for low-benefit States to improve access over time?

Will legitimate health care needs of a rapidly growing elderly population be considered?

Will Federal financial support continue at a level sufficient to avoid a shift in the proportionate burden to States and localities so

as to avoid any even more pronounced two-tiered system of health care?

Based upon preliminary information now available to us, the answers to these questions are not encouraging from either a beneficiary or a State perspective.

Because of these concerns, our recommendation is to postpone consideration of any medicaid cap proposal and proceed instead with an evenhanded course of cost containment in all federally financed health care. Such a course should include, at least, the six following elements:

One, significant statutory grants of program flexibility to State medicaid programs;

Two, retention of congressional oversight with regard to access and State maintenance of effort;

Three, application to medicare of the principles of prospective rate setting in hospitals;

Four, use of prudent buyer concept in both medicare and medicaid;

Five, aggressive promotion of the proven success of the HMO approach for all federally financed health benefits.

And, finally, six, streamlining, but retention of health planning, certificate of need, and utilization review processses.

In our view, this six-part program will be much more effective in controlling health care costs than the proposed cap, and does not contain the compound risk of further limiting access to health care for poor people while at the same time encouraging rampant increases in the broader health economy.

Thank you.

Senator DURENBERGER. Thank you very much.

Mr. Allen.

Mr. ALLEN. Mr. Chairman, members of the committee, I support strongly the statement of the APWA. Further, on behalf of the medicaid directors, I strongly support the statement that Mr. Reilly has made about objecting to the administration's cap of medicaid next year.

There are a lot of misconceptions about what medicaid is and what it isn't, and I think these misconceptions are a function of misunderstanding. We, in the States, view medicaid as a form of national health insurance for the indigent, the poor. It serves the most needy in our population. The vast proportion of the money we spend on medicaid is spent on the aged, the blind, the disabled. Very little is spent on the classic AFDC welfare case.

And, yet, there is a body of opinion in this Nation that there is a lot of fraud, there's a lot of abuse, and we submit, as State medicaid directors involved in administering these programs, that that's not true.

The primary problem is that medicaid is a health program in a very expensive marketplace. Inflation is the problem, and until we get a handle on inflation, then we can't contain medicaid costs. Putting a 5-percent cap on it will in no way allow us to achieve cost control as the Congress of the United States wants it, and as we want it, too.

In fact, the 5-percent cap has a more severe impact on those States that are experiencing financial stress. This is because we

who have been in this position have been trying for several years to contain costs, and the 5-percent cap will just exacerbate the problem.

Related to specific recommendations as an alternate to the 5-percent gap, we strongly feel that somebody has to get a handle on medicare costs.

Medicare is the largest Government health entity and third-party payment system in the health field. In our State, for example, they are about 25 percent of the hospital's budget. They are under a reasonable cost formula, which has a tendency, and has for years, to inflate costs in that very expensive sector at a greater rate than a perspective system, for example, would.

On the other hand, medicare seems to be exempt from the many rate setting methodologies that medicaid States have experimented with to control this very expensive sector.

In the same area, medicare tracks physicians' fees using a usual and customary prevailing fee approach. That, in and of itself, will cause rates that are paid to physicians for services to rise at a faster rate than normal inflation, because the marketplace is controlled by the provider.

In both of these areas, we feel that a lot more can be done in controlling total health costs than any arbitrary cap of 5 percent on medicaid only.

By the same token, we strongly recommend—and I understand the administration has promised a relaxation of rules concerning—the use of prepaid health plans, HMO's, for example; and utilization controls over what services you can and cannot provide. The use of PSRO's, for example, as determinants of utilization review has not been a cost effective exercise. Relaxation of controls on all of these items would assist us immensely in controlling costs in the States.

And, finally, I guess—we've submitted a separate statement which details some suggestions more clearly, and I ask your staff's attention to those because we think that is the way to go if you really want to contain medicaid costs.

Senator DURENBERGER. OK. Thank you very much for your testimony.

Do you agree with the list that Mr. Reilly gave us of the five broad areas of cost containment: State flexibility, oversight of maintenance of effort, prospective reimbursement for medicare, prudent buyer on both, greater utilization of HMO's and some change in, but a maintenance of our utilization review, health planning, and PSRO effort?

Mr. ALLEN. Very definitely. I didn't repeat them because—I do strongly support them and we have used them effectively in Michigan within the law.

Senator DURENBERGER. Now, you also made the observation, I think, in your testimony that the cap is tougher on States that have been trying to do something to get more quality of service for the dollar.

Could you elaborate just a little bit on that?

Mr. ALLEN. Well, I guess the best way to do it is to use Michigan as the example.

Senator DURENBERGER. Please, I'd appreciate it.

Mr. ALLEN. Michigan has the highest unemployment rate in the Nation. Our unemployment rate, statewide, is over 13 percent. I think the national average is around 7.8 percent.

Now, we have, for about 18 months, been trying very hard to contain costs within Michigan in the medicaid sector particularly because medicaid also happens to be 13 percent of our State's budget. Last year in the State of Michigan for the first time since 1932, our budget was lower than the prior year and medicaid was one of the main reasons that we've had this problem between low revenue and high expenditures. So, we have been using every imaginative initiative to contain costs in health care. To the extent that next year's medicaid budget is only a little over 6 percent increase over this year's budget and with the rising case load and 15 percent inflation in the health care field, you can see that we have had to address the problem.

On the other hand, if you put a 5-percent cap on our efforts, you are just going to heighten our problem.

Mr. REILLY. I would like to follow on that one brief point. In New Jersey, for example, with our prospective rate reimbursement, we have trailed the Nation by better than 3 percent a year over the past 3 or 4 years in the rate of increase in hospital costs. So that we have had benefit from that cost containment effort.

With a 5-percent cap, we will not have the opportunity to take up that slack because that slack is already very, very taut in our State. So, relative to a State that has not been aggressive in hospital cost containment, we are disadvantaged.

Senator DURENBERGER. On the issue, for both of you, of participation rate of physicians in medicaid, I guess, my impression is that it has been fairly low.

If we give you freedom of choice with regard to hospitals, it is my impression that you already have a certain amount of flexibility in setting reimbursement rates in a nonhospital setting. What else do we need to do to get greater physician participation in medicaid?

Mr. ALLEN. Well, there are conflicting opinions on that the effect of physician participation and reimbursement techniques. Nevertheless we have in Michigan fostered the use of HMO's in order to obtain health care services for a large segment of the medicaid population. At this time I have 6 percent of my medicaid population, some 60,000 people in an HMO setting.

Senator DURENBERGER. In one?

Mr. ALLEN. In five HMO's, and that's the largest medicaid percentage in the Nation. And it is a cost-effective way to go. Now, if we had more latitude in reimbursing physicians, then we could increase the use of prepaid health ideas, not necessarily the HMO structure.

Senator DURENBERGER. Go ahead.

Mr. REILLY. We have about 70 percent physician participation, but that figure is somewhat distorted because you will find that 20 percent of that participation accounts for 80 percent of the care rendered. So, a small percentage provide most of the care.

We had a hard time getting physician fees up. We are anomalous in that we think that we should pay greater fees in our State. We're less than 40 percent of usual and customary. One reason that we can't is that we are so constrained on the inpatient side in

terms of long-term care and hospitals. And so much of our money goes there that we don't have any to reinvest or invest in the preventive sector or the ambulatory sector, and I think we would like to do that.

Senator DURENBERGER. Thank you very much.

Senator Long.

Senator LONG. Thank you, Mr. Chairman.

With regard to States paying usual and customary charges, for many years we used to operate our system in Louisiana on that basis. We still do to a certain extent, but I recall a great number of years when the State never considered paying a doctor his usual or customary charge—for example, at the New Orleans Charity Hospital. Incidentally, the hospital is named "New Orleans Charity" because of the Sisters of Charity, a Catholic order, that provided the nursing care there. They provided a very high quality of care there.

The death rate there was the same as it was in a private hospital when they had the proper administration under my father, and that was how it was from that point forward. You had the same doctors performing operations there that were performing operations in those private hospitals. They were willing to do that, and I believe that for many years it was done without compensation. They were performing a service for their fellow man, but they were also getting a lot of valuable experience.

Would you have to pay the same fees for doctors to care for the indigent as are paid these doctors when they treat a wealthy client who can pay a large amount?

Mr. REILLY. I don't think we have to, and I don't think the medical community expects it, at least in our State they don't, but when we're paying less than 40 percent of the normal fees, there are some significant problems. I think if we were in the ball park of 65 or 70 percent, we would get much wider physician support.

They recognize that it is a public program with tax dollars, and that we can't pay what the private market can pay.

The problem with the charity medicine, however, if you look at it over 10 or 15 years, is that while in many cases it was quite excellent, and the care was very good, it did tend to be acute care, and it didn't tend to deal very well with the ambulatory preventive sector.

And I think if you look at the health statistics for the poverty population in the United States, you can see the remarkable benefit of both medicare and medicaid by opening up that issue of access. Not to say that good care didn't occur in some cases before that.

Senator LONG. Do you want to comment on that?

Mr. ALLEN. I was going to support the idea that charity should be used wherever practical. However, in our State we have over a million people on medicaid out of a 9.2 million population. Because of high unemployment it would be very difficult for us to get access to charity health care for a million people.

To echo Mr. Reilly, we are paying very low ourselves. We are not even covering the overhead in a doctor's office at the present time, and we should.

Senator LONG. Well, I can rememer a time when one of the nicest things you could do for someone was to get him admitted in New Orleans Charity Hospital where he could get himself some free hospital care and it was a great favor if you could get somebody in New Orleans Charity to be treated.

But then we got this effort by the bureaucrats in Washington who wanted to fix it so that the indigent have a choice.

Now, outside New Orleans you have the Oschner Foundation Hospital. Dr. Oschner was at one time the chief surgeon at New Orleans Charity and a great doctor. I mean, he's a little old now, but back in the time when he was making his famous reputation, he was a house surgeon at New Orleans Charity.

Nowadays, the Federal bureaucrats want to offer people the choice of going to the Oschner Foundation Hospital or to New Orleans Charity.

Now, I have been in both. I am familiar with both of them. I've been all through both of them, and Oschner is great, but it is very expensive. It's a topnotch hospital, there is no doubt about it. I think it can compete with any hospital anywhere in the world.

But when we're talking about spending the taxpayer's money, is it appropriate that we would have to let patients choose some very expensive places that provide about everything one could ask for? We also have very fine hospitals that treat large numbers of people that can't quite meet the same degree of sophistication as Oschners. Is it reasonable to try to offer every patient the choice, especially when the taxpayers are paying for it, of having the most expensive that the good Lord can offer?

Mr. REILLY. We agree that unlimited freedom of choice has actually become a barrier to access to good health care simply because we can't afford it. However, in limiting freedom of choice, we think that it has to be done carefully, because, we think, in general it's better to have access to as broad a mainstream of health care as you can.

One classic example is laboratory service. No person chooses their clinical laboratory. There is no reason why we shouldn't be able to bid on a competitive basis five or six regional clinical laboratories in New Jersey or in Michigan and get the benefit of competition and competitive purchasing because you don't choose your clinical laboratory and I don't either.

Senator LONG. I just wanted to get this matter straight that when the taxpayers are paying for it, I don't think we have to offer people who are getting something for free, at taxpayers' expense, the most expensive care that you can find anywhere in the area.

But hasn't that been about the way it's been working?

Mr. ALLEN. The problem is real and I think we should in some cases limit their choice to ambulatory care. However, when it comes to where we spend most of our money, you have got to look at the anatomy of the medicaid expenses. We spend 70 cents of every dollar on institutional care. And medicaid clients don't choose their hospital or their nursing home overtly. Somebody usually chooses it for them. And freedom of choice is a two-edge sword because the most expensive hospitals in our State, and I think it is true in New Jersey and others, are teaching institutions.

One of the most expensive in the State is the University of Michigan Hospital.

It is also the largest Medicaid hospital provider in the State, and it is also State supported. And so you get in this circle where you are State supporting an institution that is very high cost. If you buy the service from a $200-a-day hospital down the street, you will dry up the cash flow of this expensive teaching institution and you find yourself in a box. This is true of public hospitals also.

Senator DURENBERGER. Thank you.

Senator LONG. Could I just ask one further question?

Senator DURENBERGER. Yes.

Senator LONG. Well, can't we separate out the expense that has to do with teaching and pay for that separately, apart from the expense for the care of the patient?

Mr. ALLEN. Yes; I think there is potential to do that, but I have never seen it done.

Senator LONG. Well, it seems to me logical that we ought to do that.

Senator DURENBERGER. You will see it sooner or later.

Senator Grassley.

Senator GRASSLEY. Mr. Chairman, I don't have any questions, but I would like to comment in a little more general fashion than the questions so far have been pointed toward.

I think I sense the frustration of people who are in charge of programs within the States and the State Governors and some of the State legislative leaders, and particularly those people who are in charge of hospitals that there will probably be some readjustment if a cap is put on. And maybe it is not realistic to think that there will be a cap put on. Maybe it can't get through the congressional process here.

But some compromise of the existing setup where there is no necessity for prioritizing claims on the Federal Treasury as with no cap and the States decide what they want to spend and the Federal Government will match it, it seems to me to encourage a lack of discipline because the people that are making the decisions on what to spend and where are not the ones that have the responsibility for raising the money like we do here. At least, somewhere between 53 and 83 percent of the money, I guess, for medicaid comes from the Federal Government varying from State to State. And, so we bear that responsibility for raising it, giving it to the States, but obviously with some guidelines, but almost to a point where there is no incentive to police. So, it does violate that one principle that somewhere along the line those that have the responsibility for spending it—have the right to spend it, ought to have some care that it be spent wisely.

In other words, the level of government that spends it ought to have some of the responsibility.

I don't know how that is going to come other than more Federal regulation, which we don't want, because that is going to federalize it totally, or else through such a cap.

The second point is that just basically medicaid is an example of some Federal programs that kind of view the Federal Treasury as a bottomless pit where there doesn't need to be any prioritizing of claims upon the Federal Treasury and that just doesn't square with

the basic facts of economic life—that there is a limit on what people will pay in taxes. There is a limit on what public officials can do with that money, and when there isn't, there isn't discipline.

If we would adopt a philosophy that is involved with medicaid on a whole vast array of Federal programs, and there are only a few that don't have a cap, there wouldn't be any end to what we would be doing here, and, of course, with our unwillingness to raise taxes through a vote, and otherwise raising the money through the inflation or else raising the money by devaluing the dollar by running the printing presses to a greater extent, then there is no fiscal discipline here either, and so we have to institute that fiscal discipline.

You not only have to institute it on the tax end, but you have to institute it on the spending end as well. So, you know, I suppose hospital officials, Governors, administrators of State programs, as you are, look at this as an effort of Congress to punish you. It is not that at all. It is an effort to punish ourselves for our prolific spending and to reestablish some—or force some priorities here within the decisionmaking process in Washington.

Mr. Allen. Mr. Chairman, may I respond?

Senator Durenberger. Yes; go ahead.

Mr. Allen. The States are as interested as the Federal Government in containing costs, particularly those States like New Jersey and Michigan that spend 50 cents for the 50 cents the Federal Government spends.

So, a 5-percent cap really hurts a State that is trying cost-containment initiatives, or only gets 50 percent match. It is more to the advantage of those that get a 70-percent match not to contain costs and that isn't what you are trying to do. You are trying to take the ones that are more conscious of the problem and cut them down.

So, there needs to be some evening process in lieu of a 5-percent across-the-board cap. We suggest that there should be some incentives built into the system that would encourage the States to establish cost containment initiatives. For example, in nursing home care, coming up with alternatives to institutions. Coming up with rate-setting methodologies to constrain hospital costs where we are really spending a lot of money. These kinds of things—because we don't think it's a bottomless pit, believe me. Our legislature is very uptight about every dollar we spend on this program.

Senator Grassley. I don't reject your suggestions. I, in fact, encourage them. All I am simply saying is that we have to depart from the 1½ decades practice that there isn't any limit to what we can spend.

Mr. Reilly. Senator, the way to depart, we would suggest is to permit us to be aggressive in cost containment. We have felt over the years that when we turn to the Federal Government for support, that is where the problem came in with the bias toward cost reimbursement at institutional settings. And we are as much, or more interested in trying to control this budget as is the Federal Government. We need some help in that direction giving us those grants of authority to get tough and bring competition into the system.

Senator GRASSLEY. Less Government regulation, or less Federal regulation in the program is going to help or hurt in your judgment?

Mr. ALLEN. It's going to help.

Senator GRASSLEY. It is going to help.

Mr. ALLEN. Right.

Senator GRASSLEY. Do you agree with that, sir?

Mr. REILLY. Yes.

Senator DURENBERGER. Thank you very much, Senator.

Senator Byrd.

Senator BYRD. Mr. Allen, both you and Mr. Reilly in your colloquy with Senator Long admitted that there should be a limit to the freedom of choice, so to speak?

Now, how is it limited now? How do you limit it, Mr. Reilly?

Mr. REILLY. At the present time it is unlimited. It is virtually open ended. Any health care provider who is licensed and has not been barred from the program for a program integrity offense is permitted to provide services. It is unlimited at the present time.

Senator BYRD. Well, I gathered from what you said that you felt there should be a limit and that you had a limit?

Mr. REILLY. No; I feel there should be a limit but the limit does have to carefully weigh how far the limit goes before it begins to impede beneficial and reasonable access to service and takes us in the direction of a two-tier or a two-class system of health care.

I think we can make a lot of progress in efficiency and economy before we cross that line.

Mr. ALLEN. Senator Byrd, there are two parts to the freedom of choice issue. One, is freedom to choose a provider and then there's the provider's freedom to choose us.

The provider, at the present time, assumes the right to do business with us, and the recipient assumes the right to do business with any provider they want to because they have a credit card to do just that.

What we would suggest is that as a prudent buyer of services, if we had the latitude, we could deal with certain providers that were more cost effective than others. That is freedom of choice on the provider's side. And on the recipient side, we could perhaps channel the recipients' health care services to cost-effective providers, such as prepaid health plans, and the like.

Senator BYRD. And you cannot do that now?

Mr. ALLEN. We can't do that now.

Mr. REILLY. We do limit people if they have a record of abuse. Michigan has a lock in program, I believe, and so do we in New Jersey where we can give them a limited eligibility card to tie them into certain physicians and certain pharmacists only, but that is only a small percentage of the people who participate in the program.

In general, people have universal access.

Senator BYRD. You can't direct which hospital they go to?

Mr. REILLY. No.

Mr. ALLEN. No.

Mr. REILLY. Or which doctor.

Senator BYRD. And you feel that the law should be changed to permit that?

Mr. ALLEN. Under certain controlled circumstances, yes.

Senator BYRD. Now, you mentioned in your dialog with Senator Grassley that less Government regulation would be helpful and could you indicate what chages should be made in the law?

Mr. ALLEN. We have submitted a list of specific parts of title XIX, which governs medicaid, that should be liberalized or modified concerning the reimbursement mechanisms. What we should pay a hospital, reasonable costs, for example; what we should pay a doctor, both for medicare and medicaid; how we should negotiate contracts with prepaid health plans; the freedom of choice issue we just talked about; client cost sharing. We're severely limited on the client's ability to share costs. So, we have submitted a list of specific laws and regulations that need to be loosened up.

Senator BYRD. Just one last question. I was intrigued with what you mentioned, Mr. Allen. I'm not sure whether I heard you correctly. Did you say that the State of Michigan has actually reduced its budget for the current year, vis-a-vis as compared with the previous year?

Mr. ALLEN. Yes, sir.

Senator BYRD. Actually reduced it below what it was last year?

Mr. ALLEN. Last year the State's part of the budget, you know, there is a State and Federal part, the State's part of the budget last year was $300 million more than this year.

Senator BYRD. That is for all services?

Mr. ALLEN. That is for all services. So, it is an absolute reduction over the prior year.

Senator BYRD. That shows that there can be a reduction in Government spending if there is a will on the part of those who operate the particular State, or the Nation, or the locality?

Mr. ALLEN. That's true. And the people of Michigan have bitten the bullet. Unfortunately, I think if you put a 5-percent cap on us for Federal support, we'll break our teeth because we just can't go further—it will push us underground.

Senator BYRD. I think the Federal Government has got to bite the bullet and the Members of the Congress have got to bite the bullet, too.

Mr. ALLEN. Yes, sir.

Senator BYRD. Thank you, sir.

I congratulate Michigan.

Senator DURENBERGER. Thank you, Senator Byrd.

Senator Bradley.

Senator BRADLEY. Thank you, Mr. Chairman.

I'd like to say a special word of welcome to Mr. Reilly who is here today sharing with the committee his view of this issue, which I think is one that should be instructive.

I wonder if you could walk through the steps that you go through in New Jersey in order to insure that you have some incentive systems to control costs and that you do, in fact, control costs. Explain how your approach works and how the situation might be different in a State that didn't have a rate-setting commission.

Mr. REILLY. The principal tool in controlling costs in the medicaid program is to limit the rate of growth in your institutional providers, be they hospitals or long-term care facilities, nursing homes. That is because they will constitute between 60 and 70

percent of your program expenditures and the most effective way I know of doing that is to have a cost based reimbursement system that is prospective in nature and not retrospective. So that an institution knows what it can count on from support at the outset of the year and knows that it cannot come in with a blank check at the end of the year and expect to be reimbursed.

There are various levels of sophistication in that process. We are now trying in New Jersey something called the diagnosis-related group system that hones in on the specific illness and tries to set a rate for that. And framers of that system believe that it is the state of the art and the most effective way to deal with hospital costs.

Beyond that, it is terribly important in an entire medical assistance program, particularly your large State, to have a very effective claims payment review and monitoring process, and that means you must run on computers when you are dealing with 12 or 14 million bits of information in a period of a month.

You must also have a well-developed program integrity effort to deal with those few individuals who will attempt to defraud the program or abuse the program. You have to have a good relationship with the criminal justice system in order to prosecute people when that becomes necessary.

Senator BRADLEY. Since you have set up this kind of system, could you tell us how the proposed medicaid cap would affect you differently than it might affect a State that hasn't done this?

Mr. REILLY. We don't have the opportunity now to do those things because we have already accomplished it. Our system, we think, is as tight as we can reasonably make it although we are always trying to improve.

The State that has not had an aggressive cost containment and has not had aggressive program integrity; has not had aggressive claims management, has some opportunities to get by with less money.

Senator BRADLEY. So, you argue that States that have actually put into place these mechanisms to control costs should have some relief from the cap; is that correct?

Mr. REILLY. There ought to be some way to factor in program performance in setting a cap if we get to a cap.

Senator BRADLEY. Mr. Allen, did you want to say something on that?

Mr. ALLEN. Well, I'll give you a specific figure. We have totted up this year all the cost containment initiatives that we have accomplished in the past couple of years, and on an annual basis, we have reduced our budget this year $238 million in medicaid from what it would be if we hadn't put these initiatives in place. That is 17 percent of my budget. Now, that was done without any great Federal impetus. It was done because the State of Michigan recognized the problem and had to move out. That's a lot of dough.

Senator BRADLEY. It sure is and I think it speaks well of your efforts. We should try to take into consideration those States that have actually succeeded in keeping these costs down.

Mr. ALLEN. Amen.

The CHAIRMAN. Do you have a record of that in your statement?

Mr. ALLEN. Sir?

The CHAIRMAN. Is that in your statement the things you did to achieve that savings?

Mr. ALLEN. No, but I have it here. I can add it to my statement. I have a complete list by item.

The CHAIRMAN. Why don't you make that a part of the record?

Mr. ALLEN. Yes, sir, I will.

MICHIGAN MEDICAID COST CONTAINMENT PROGRAMS

Policy	Implementation date (fiscal year)	Annual savings	
		Fiscal year	Amount (millions)
Alternatives to institutional and nursing home care	1975-76	[1] 1981	$150.0
Third-party liability	1977-78	1978	18.0
		1979	27.3
		1980	39.5
		[1] 1981	46.0
Fraud and abuse	1978-79	[1] 1980-81	4.0
Outpatient lab	1979-80	1979-80	1.0
		[1] 1980-81	2.1
Routine testing	1979-80	1979-80	.5
		[1] 1980-81	.5
Automated testing	1977-78	1977-78	1.3
		1978-79	1.3
		1979-80	1.3
		[1] 1980-81	1.3
Recipient monitoring:			
Pilot	1978-79	1979-80	.5
Expanded	1979-80	[1] 1980-81	1.0
Second surgical opinion	1979-80	1979-80	2.0
		[1] 1980-81	4.0
Volume purchase eyewear	1979-80	1979-80	.25
		[1] 1980-81	.50
HMO's	1974-75	[1] 1980-81	4.5
Generalists versus specialists fees	1978-79	1978-79	1.0
		1979-80	2.0
		[1] 1980-81	2.0
Pharmacy copayment	1980-81	[1] 1980-81	3.0
Prospective reimbursement/long term care	1978-79	[1] 1980-81	15.0
Prospective reimbursement/hospitals	1979-80	[1] 1980-81	5.0
Ambulatory fee differential	1979-80	[1] 1980-81	1.0
Total fiscal year 1980-81 savings			238.2

[1] Projected

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Actually, these last two requests are the area that I want to focus in on.

You said Michigan achieved 17 percent savings; is that correct?

Mr. ALLEN. Seventeen, yes.

Senator BAUCUS. Seventeen percent.

Mr. ALLEN. Right.

Senator BAUCUS. And my understanding is that New York also has experienced significant medicaid savings; is that correct?

Mr. ALLEN. They have had great improvements in the past couple years, yes.

Senator BAUCUS. Do you know roughly what their savings are?

Mr. ALLEN. No. But knowing the magnitude of their problem, it is two to three times ours.

Senator BAUCUS. Do you know—I'm sure that is true on an absolute basis, do you know what their saving has been on a percentage basis?

Mr. ALLEN. No, I do not.

Senator BAUCUS. You apparently are somewhat familiar with the Michigan savings, and I appreciate the request of the chairman who asked for a submission of an itemized statement.

Could you just generally indicate now, to the degree that you can, where those savings occurred?

Mr. ALLEN. Yes. The majority of the savings accrued in long-term care—nursing home care. The alternatives to institutional care that we have are quite extensive. To the extent that we have more people receiving help in their home or in a congregate living situation than we do in nursing homes.

We only have 30,000 people in nursing homes in the State of Michigan, which, as a dollar percentage, means it is only 30 percent of the medicaid budget. Nationally, long-term care is about 45 percent of the medicaid budget. So, our biggest effort in cost containment has been in not letting people go in to nursing homes when they can be kept in their own homes more economically.

That is the major one and amounts to $150 million.

Senator BAUCUS. Out of what? $300 million?

Mr. ALLEN. Out of $238 million. So, it is almost 60 percent of the total.

The next largest one is in the area of third-party liability. There are a lot of people in Michigan that have other insurance because they are the products of divorces involving UAW people who have a strong health plan as part of employment contracts. In this respect there are a lot of people in this Nation that have other insurance coverage but are on medicaid. We have identified 35 percent of our medicaid population as having other insurance. So, this year we are collecting in cash, or sending bills back to insurance companies to the tune of $46 million.

Senator BAUCUS. Are there any people in Michigan who complain about fewer people going into extended care, I guess, nursing homes, and so forth?

Mr. ALLEN. Yes.

Senator BAUCUS. What's the complaint in Michigan?

Mr. ALLEN. Well, we hear periodically, in isolated instances, that they are being kept in hospitals too long because they can't find a bed or that the bed is not close enough to their home, and so forth. But it is not what I would call a loud outcry, it's an episodic thing.

Senator BAUCUS. Is there any reason why other States couldn't achieve the same savings as Michigan?

Mr. ALLEN. Not at all.

But there has never been an impetus, you know, in either the Federal or the State law to do this.

Senator BAUCUS. Do you have any idea as to how much more savings Michigan could achieve if Congress were to allow the greater flexibility that you request?

Mr. ALLEN. Well, that's our problem. We have been working so hard at this issue, we are up against the wall. We are getting to the marginal return and I am talking now something less than 5 percent of my budget could be saved, if we had more flexibility.

This further savings would be primarily in the hospital area where we would be able to get more for the dollar. Also perhaps in the ambulatory prepaid system, though there are no big dollars left there now.

Senator BAUCUS. What would it be in the hospital area?

Mr. ALLEN. Well, I would estimate possibly as much as next year with our budget of $500 million, close to $25 million.

Senator BAUCUS. And what would you do to reduce hospital costs?

Mr. ALLEN. Well, I think we could go to a more stringent cost-related formula so that we wouldn't recognize excessive inflationary expenses.

Senator BAUCUS. Thank you very much.

Senator DURENBERGER. Thank you.

Senator Dole.

The CHAIRMAN. I have no questions, I was just interested—I was wondering how we could save some money. If we can find some better way than the cap, I'm certainly willing to listen. That is why I asked if you had the list with you.

Mr. ALLEN. Yes, I do.

The CHAIRMAN. It is probably a big list.

I appreciate your testimony.

Senator DURENBERGER. Could I ask each of you just one question that I've been asking at all of these hearings and that is on the future role of Federal and State government in the provision of health care to those who depend on some subsidy for their health care. And the suggestion is being made that as we look at the appropriate roles or functions of the various levels of government, that it might be appropriate for the Federal Government to finance—fully finance health care, for example, both medicare and medicaid and, in effect, at some point to arrange a swap with the State, where we give them back what they used to have in education, highways, and housing, and a variety of things, and take over medicaid.

What is your opinion as to what might happen both to the issues of access to quality care and the cost of care if we were to move in that direction and, in effect, federalizing medicaid?

Mr. REILLY. Initially it strikes me as a very attractive proposal. I think that there would be some problems in sensitivity of administration at the local level in a federalized health care program because of distance and bigness and how hard it is to change the computers in social security, and very practical reasons like that.

I think it would free up a good deal of State money, depending upon what maintenance of effort was required, in order for us to operate at the local level in many of the traditional functions. I think that in the long run it would probably better serve access than going in the other direction of decentralizing the health care to the States.

Senator DURENBERGER. Mr. Allen.

Mr. ALLEN. As might be expected when you have 49 States and five territories involved in the issue you will get several opinions. I have a feeling that the higher you escalate management of a program like this, the more expensive it is going to be. If you make the Government—the central government responsible for health

care for the poor in Michigan, I know that your unit cost is going to go up, because the people of Michigan currently have a very stewardship oriented approach to administration of medicaid. It is their money. It is their physicians; it is their community hospital. So, they are interested in making sure that they get the most for the dollar, the tax dollar that they contribute to the income of those places.

On the other hand, remote management of a program by the Federal Government is expensive. I think medicare is a classic example of an expensive program that is just going to get more so because of the very nature of its structure. There is a difference of opinion on federalizing medicaid.

Senator DURENBERGER. But that is true insofar as government, however, you define it, as making the decisions for people relative to where they are going to get their health care and how it is going to be paid for.

If the providers of health care and the consumers of health care were making those decisions in some way, might we then look to a federally financed system?

Mr. ALLEN. Possibly in a concept sense, but most of the people who need health care that are poor, are disadvantaged, probably mentally as well as physically, and I don't think that they are capable of making that kind of a reasonable choice.

Senator DURENBERGER. I hate to let it go at that, but I think it is time.

Thank you both very much for coming.

Mr. ALLEN. Mr. Chairman, I have one more concern.

Senator DURENBERGER. Yes.

Mr. ALLEN. The issue is a rather parochial one. We are concerned in Michigan with our high unemployment rate that the Federal match of 50 percent just doesn't realize our unemployment situation. The current formula just doesn't do it. And we are in great difficulty because of it. There is a flaw in the 50 percent formula.

Senator DURENBERGER. And quotas on Japanese cars aren't going to help you either.

Mr. ALLEN. No, none of those things.

Senator DURENBERGER. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

The one thing that strikes me is the anomaly in placing a cap on medicaid and not a cap on some other entitlement programs that are going up at as great a rate perhaps than medicaid expenditures, and what, in your view, is the reason why the Administration poses a cap on medicaid, but not, say, a cap on medicare?

Mr. ALLEN. Well, you know, I read an article in the Wall Street Journal the other day and the lead line was, "We've got to do something about this medicaid mess." And, I think, like I said, my comments earlier there is a preconceived idea that medicaid is a mess. It is not cost effective, and I submit, and all of us medicaid directors submit that that's not true.

Senator BAUCUS. That it is more cost effective than, say, medicare?

Mr. ALLEN. Oh, definitely. Definitely. It gets more attention both at the local scene and at the Federal level than medicare will ever get.

Senator BAUCUS. So why do you suppose the administration puts the cap on medicaid?

Mr. ALLEN. Because——

Senator BAUCUS. Because they don't know that, or what is the reason?

Mr. ALLEN [continuing]. It is somebody else's responsibility to administer, that's why.

Mr. REILLY. It may be lack of information. It may be the nature of the beneficiary, either of those reasons, or both.

Senator BAUCUS. Thank you very much.

Senator DURENBERGER. Thank you for the question. And that accents something we asked earlier in the hearing and that is for your ideas on changes in medicare, and I hope that you can get as much information in that area to us as possible.

We thank you very much.

Mr. REILLY. Mr. Durenberger, I would also like to submit for the record a statement by Tom Russo, our medicaid director in New Jersey, if that would be permitted?

Senator DURENBERGER. That is fine. We will accept that as part of the record and appreciate it very much.

[The statements of Mr. Reilly, Allen, and Russo follow:]

STATEMENT BY THOMAS M. RUSSO

SUMMARY OF PRINCIPAL POINTS

The Medicaid poor and needy require a program of full benefits for health care services.

The State of New Jersey is unable to provide full Medicaid benefits with the administration's proposed drastic spending reductions.

Many Medicaid persons will be seriously hurt and will face life threatening situations with the proposed Federal reductions.

A less severe and traumatic Medicaid reduction program should be followed by the Federal administration and legislature.

The "cry of the poor" must be heard and heeded for the ultimate benefit of the nation.

Mr. Chairman and members of the Finance Committee of the United States Senate, I am Thomas M. Russo, Director of the Medicaid program in the State of New Jersey. Thank you for the opportunity to make this presentation concerning the administration's spending reduction proposals relative to the Title XIX Medicaid program.

Gentlemen, I am certain that you have heard the phrase and I quote "The Lord hears the cry of the poor. Blessed be the Lord." In the context of the hearing today, I might paraphrase that quote by saying "The Lord hears the cry of the poor. Blessed be those in the Congress who hear and heed this cry."

As the Director of the Medicaid program in one of the big ten Medicaid States, I know both personally and professionally of the tremendous need for and the good that the Medicaid program does for the poor, the elderly, the disabled, the blind, the needy and the children in the State of New Jersey. We all too often hear charges concerning waste, inefficiency, and fraud and abuse in the Medicaid program, often without ample supporting documentation to categorically uphold such allegations.

We all too seldom, however, hear about the tremendous benefits derived by our citizens because of the very existence of the Mediciad program. Very few people in high places, except when there may be a crisis such as the one I truly believe we are facing today, will or do recite the thousands of daily occurrences supported by Medicaid funds for our poor and needy people whose very lives and existence have been saved because they received the operation that was required, because they were able to obtain the expensive life sustaining drugs that are needed, because they could obtain renal dialysis services regularly, because prosthetic and orthotic devices and medical supplies were readily available to help them sustain them-

selves. In short, because there is a Medicaid program and a caring government that has recognized and provided for these needs for the millions of our citizens.

Many of these citizens, I might add, are the very ones who in the past have fought America's battle on foreign soil, who have provided the productive capacity that has helped to make America great and who have reared the generations of children who are now making America's basic decisions. The Congress cannot turn its back on these people and on those who in future generations America must in large part depend, these of course being the children of the poor and the needy.

There are those who say that the proposed reductions in funding for the Medicaid program will not hurt those who are truly in need. This I can assure you is not true. The needy will be hurt and in some cases will be hurt very badly, to the extent that their very existence may be in danger.

Based upon my current knowledge of the proposed Federal capping formula for the Medicaid program, the State of New Jersey will receive 2.86 percent of the total national funding for the Medicaid program. If the figure of 17.2 billion dollars at the national level for fiscal year 1982 is correct, this will mean that the State of New Jersey will be provided with 492 million dollars to run its Medicaid program for fiscal year 1982. That amount, standing alone, represents a potential loss of 37 million dollars in the amount of Federal money required to fund New Jersey's Medicaid program with its current benefit packages and reimbursement levels. Coupled with State-Federal matching funds, the reduction represents a potential loss of 74 million dollars in fiscal year 1982 for medical services, pending possible offsets from other programs that might affect Medicaid eligibility.

There are some areas in which a re-emphasized cost containment program can save some of this money without materially affecting benefit packages. However, gentlemen, I can assure you that those areas in an efficiently operated Medicaid program, such as that exists in New Jersey, are very few without either reducing or eliminating reimbursement to providers or services to recipients. Even with absolute flexibility on the part of the State to operate its Medicaid program free from any Federal restraints, it is absolutely impossible to realize within one fiscal year a total saving equal to 74 million dollars without adversely affecting the health care of the needy and the poor. Of necessity, some program must be sacrificed.

In this regard, there are no low priority services, nor are there optional services in the eyes of those for whom a previously available benefit has been curtailed, withdrawn or is no longer available. To obtain such a benefit once it has been eliminated, the Medicaid recipient must find the means to obtain that service from an already meager subsistence allowance. Such choices only make the poor poorer and the needy more needy.

I truly believe that the State of New Jersey and all the other states in this great nation are as interested as is the Federal Government in economy and efficient operation and in beating back the ravages of inflation. However, this should not be accomplished at the expense of those most needy in our society. A total Federal cap on expenditures at the State level should not be considered by the Congress at this time. At the most, a partial Federal cap, possibly at one half of the current proposed level or as proposed by the National Governors' Association, should be considered while at the same time giving the states the full flexibility that they need to independently operate their Medicaid programs and to initiate their own cost containment programs. Anything less, in my opinion, will leave totally unmet the full range of health care services required by our needy people.

Gentlemen, I could provide you with a litany and a list of those areas and items that should not be touched by the proposed capping program and could provide you with a similar enumeration of alternatives. However, many of those who are appearing at today's hearing are providing such documentation. My simple purpose is to urge that you not turn your back on the poor and the needy or the handicapped and on children by taking needed Medicaid money away from the States. Do not take medical and health care away from the sick. Give them the means to have their medical bills paid and to free their shoulders of this burden. I urge that you hear the cry of the Medicaid poor.

Thank you again for the opportunity to express these views on behalf of New Jersey's Medicaid program.

Testimony of Gerald J. Reilly

Mr. Chairman, members of the Committee, my name is Gerald J. Reilly and I serve as Health Care Committee Chairman of the National Council of State Public Welfare Administrators of the American Public Welfare Association. I am also Deputy Commissioner of the New Jersey Department of Human Services.

I will discuss the views of the people, who are actually responsible for the State Medicaid programs, with regard to President Reagan's Medicaid recommendations.

My colleague, Mr. Paul Allen, will then describe our specific proposals for program improvement.

Attached for your consideration is a resolution approved by the National Council of State Public Welfare Administrators on President Reagan's Medicaid proposal.

State Medicaid managers want the most effective and efficient program. We already have sufficient impetus to perform effectively, but we lack sufficient authority to manage efficiently.

States are paying 44 percent, or $12.8 billion, of the program cost in 1981. For most states, Medicaid is their single largest expenditure. Our own efforts to contain program costs have become more intensive and innovative as state and local budget limitations tighten. The existing authority in federal law and regulation for prudent program operation has become extensively used for beneficial and responsible purposes. As a result, Medicaid appears to be the msot cost efficient federal health services program.

The program certainly has problems, but the easy solutions have long been implemented. The major barriers to further improvement are in federal law and regulation. Greater administrative authority and flexibility for states, as well as fewer and simpler federal requirements, are essential to meet federal and state budget objectives with minimal adverse impact.

Accordingly, we support the President's intention to eliminate or reduce excessive federal constraints upon efficient service delivery and effective administration. However, we must raise serious concerns about the multi-year cap on federal Medicaid spending increases as it is unnecessary, inappropriate and unreasonable. Adjustments in federal spending for health services can be more equitably balanced between Medicare and Medicaid than has been proposed and, in so doing, the so-called "social safety net" features of both programs can be maximized.

Concern must be expressed that the magnitude of the President's proposed cuts in the federal commitment to Medicaid cannot be met, especially in later years, without serious dismantling of the program. The full impact of the cuts cannot be absorbed by state and local budgets, even with new program flexibility and deregulation. Major reductions would have to be made in eligibility, services, or reimbursement. Furthermore, the states have very limited capacity to respond immediately to such a drastic program change. Aside from the expected legal challenges to the state adjustments necessitated by the cap, such immutable factors as the planning and implementation of changes, notice requirements, and state legislature schedules hinder a state's ability to act quickly. In fact, 40 state legislatures will be out of session for the year by June 30.

A critical issue for states is the extent to which flexibility is provided by specific, permanent changes in statute and regulation, rather than by congressional delegation of greater discretionary authority to the Department of Health and Human Services. The more the changes are specific and permanent, the easier it will be for states to plan; to undertake long-term, cost-effective initiatives; to moderate provider and citizen demands; and to avoid legal challenges to the exercise of discretion.

The spending cap in the President's proposal poses major problems for state Medicaid programs. First, the cap is not necessary for meeting much of the President's targets for spending cuts. At the very least, states should have adequate opportunity to employ any new flexibility given to them, before imposition of an inflexible cap.

The cap is not an appropriate response to the underlying problems of health cost inflation and an aging population. the cap is directed at the consequences, rather than the causes of increased spending on health care for the poor. Medicaid merely buys services from a sector of the economy driven by cost increasing factors, notably cost and charge reimbursement methods and technological imperatives. Medicaid is expensive because medical care is expensive. Medicaid, by itself, can have little positive impact on provider practices. In fact, attempts to exert leverage often have the perverse effect of decreasing provider participation and quality of care. Medicaid should not be further weakened, while other federal programs, particularly Medicare, are allowed to continue unchecked spending.

Plans for eventual fundamental and comprehensive re-structuring of health care have been heard many times. States are seriously concerned that once in place the long-term effect of the cap will be to accelerate withdrawal of the federal government from the Medicaid program, and with it our national commitment to equal access to health care for poor Americans.

In addition, the proposed cap, is not fair in its impact on states. It fails to reflect fundamental differences among states, their varying Medicaid programs, or their individual records of performance. In particular, the cap does not distinguish between fat and lean programs. A program, in fact, which is relatively basic, efficient, and tightly administered would be worse off with its lower base of expenditures.

Ironically, as the President proposes to move the health system toward more competition, his first initiative would have the opposite effect.

Two issues with regard to the cap for which there is no apparent indication as to how they will be handled are the possible reallocation of unused federal funds and the specific GNP deflator applied. The first issue arises because some states may not be able to use all of their Medicaid allocation owing to insufficient state funds with which to match.

Several questions need to be answered about the GNP deflator. The GNP deflator is calculated quarterly, announced initially about 20 days after each calendar quarter, and revised several times as more complete numbers are available. Since the GNP deflator is computed on past information, would the caps be indexed on a projection or an actual figure? Will the cap be adjusted for actual experience in the year involved and for revisions in the GNP deflator itself? How soon in advance will states be notified of the applicable figure? We oppose the cap, but if one is to be imposed, these questions must be answered first.

Finally, as you consider the budget, please do not lose sight of the fact that the Medicaid reduction is but one aspect of a series or proposals that will deeply hurt low income people in America. In my state alone, approximately 700,000 people will be affected by the withdrawal of over $600 million in aid in a variety of programs, including home health services, child abuse, income support, food stamps, unemployment compensation, and housing assistance. This set of proposals should not be evaluated piecemeal but rather in their overall interactive impact on our people.

Resolution on President Reagan's Medicaid Proposal

Whereas, the Reagan Administration has proposed that the medical Assistance program be reduced in Fiscal year 1981, and capped at a 5 percent growth level in fiscal Year 1982; and

Whereas, the Administration incorrectly attributes rapid cost increases to alleged State management shortcomings, rather than extreme inflationary pressures in the health sector, especially in the Medicare program; and

Whereas, the Administration has not taken into account the significant cost containment efforts undertaken by States, despite present rigidities in Federal Medicaid policy, as recently documented by the National Governors' Association; and

Whereas, the Administration proposal calls for radical policy changes but fails to provide specific information on many significant State concerns; and

Whereas, the Administration proposal does not take into account differences in State medicaid programs with regard to program benefits, eligibility, and previous management and cost containment efforts; and

Whereas, State recommendations for important changes in Medicaid policy, formulated in 1976 and earlier, which had they been adopted would have slowed the upward spiral of program costs, were largely ignored by the Federal government; therefore, be it

Resolved, that the National Council of State Public Welfare Administrators of the American Public Welfare Association makes the following recommendations:

1. In accord with the National Governors' Association position, the Medicaid program should not be subject to an arbitrary cap of 5 percent growth in Fiscal Year 1982.
2. Prospective reimbursement policies should replace the inflationary Medicare principles for hospitals.
3. States should be accorded flexibility in administration of the medicaid program consistent with recommendations of the National Governors' Association.
4. The concept of a long term care block grant should be carefully considered, but any such grant must be reasonably indexed for inflation and age specific demographic changes.
5. The authorizing committees in the U.S. Congress should carefully review the administration proposals and seek more time for public hearing and comment than is possible under the budget reconciliation process and schedule; and be it further

Resolved, That the Council instructs its Health Care Committee to continue working with the National Governors' Association and other related organizations in carefully reviewing specifics of the Administration proposal as they become known, and in articulating to the Administration and the Congress our questions and comments on the proposals.

Passed by the National Council of State Public Welfare Administrators

TESTIMONY OF PAUL M. ALLEN

Mr. Chairman, members of the Committee, my name is Paul M. Allen, and I serve as Chairman of the State Medicaid Directors Association of the American Public Welfare Association. I am also Director of the Michigan Medical Services Administration.

I appreciate the opportunity to present the views of the state administrators about how the Medicaid program can be improved by opportunities for greater state flexibility. The following ideas are suggestive of what might be done with this flexibility.

Allow states to be "prudent buyers" of certain services.—The single most important change toward a more cost-effective Medicaid program would be to allow states to selectively buy services from cost-effective providers. At present, the Medicaid recipient has unrestricted freedom to choose among providers in the program. Whether an institutional provider or individual practitioner participates is almost solely their decision. The states, who after all must pay the cost, may not delete costly or poor quality providers or give incentives for patients to use inexpensive ones.

States should have the authority to restrict recipient choice of hospital and other institutional services, laboratory tests, and medical devices. States should have the ability to engage in cost saving arrangements that assure reasonable patient access to services and maintain quality care. Costs for these types of services vary greatly within localities with no discernable in quality. Substantial savings would accrue from utilization of economical providers, volume discounts, and an indirect control on provider waste, fraud, and abuse. Also, states could increase use of health maintenance organizations and other provider organizations to manage a recipient's overall health services on a prepaid, per capita basis. The quality of highly specialized services, such as open heart surgery, would be increased by directing recipients to experienced providers.

We appreciate the efforts of the Finance Committee to make such a change in last year's budget reconciliation act (Section 562 of S. 2885) and believe it should be the basis for action now. This change would greatly advance the "competitive" health care model.

Allow prospective budgets and "reasonable and adequate" payment for hospital services.—Hospital service cost increases are the greatest contributor to health cost inflation. This occurs mostly because the dominant method of hospital reimbursement is inflationary retrospective cost reimbursement. Hospitals have no incentive to hold down costs which are almost always reimbursed. This adversely impacts Medicaid, which spends about 37 percent of its funds for hospital services. It must be noted that Medicaid has little leverage on hospital costs, only paying about one-tenth of the nation's hospital bill.

Medicaid payments to hospitals must follow the Medicare method, or an alternative method based on Department of Health and Human Service specifications and requiring HHS approval. Only 12 states have undertaken the alternative route.

States would like greater flexibility such as provided for nursing home reimbursement in the so-called Boren amendment enacted in the Omnibus Reconciliation Act (Section 962 of P.L. 96-499). This provision requires payments "reasonable and adequate to meet the costs of efficiently and economically operated facilities." As you know, states have an excellent record using the flexibility already provided for innovative and constructive methods to finance nursing home services.

It is essential for states to accommodate any sizeable budget cut by being able to reduce excessove hospital payments. In a small way, it would also make hospitals cost conscious and competitive. Congressional Budget Office estimates savings of about $250 million in FY 82 if states were successful in reducing Medicaid hospital reimbursement levels by 5 percent.

Allow greater innovations for practitioner reimbursement.—Under current law, Medicaid practitioner payments are limited to no more than Medicare fee levels, as determined by a variation of the traditional "usual, customary, and reasonable" (UCR) method. States would like the linkage to Medicare eliminated and to begin to replace the common, but inflation encouraging UCR reimbursement.

States could use the extra flexibility to correct urban-rural disparities in Medicare fees, provided incentive payments for cost effective practices, increase payments for priority services, and more easily pay for managing health services to a recipient.

Permit service targeting by diagnosis, illness, or condition.—Currently, states cannot limit the amount, duration, or scope of service because of the diagnosis, type of illness, or condition. In addition, all services must be equal in amount, duration, and scope for all recipients within the group (categorically needy or medically needy.

States should be provided the flexibility, to establish coverage limits based on diagnostically related groups. Such restrictions would be preferable to dropping

many of the present services. A state would be able to target services, establish normative standards for services, and limit delivery of services to the least expensive setting.

A related problem affecting states is broad judicial interpretation of the "medical necessity" of services. States may place limits on services based on medical necessity. Some court decisions basically say that if a doctor orders a service it is medically necessary. A clear, firm definition is needed. This restricts states ability to stay within budget.

Allow localities to provide additional coverage—At present, a state's Medicaid services and eligibility requirements must be uniform throughout the state. State programs include special local coverage of services and eligibility groups with the matching funds provided by a political subdivision. This would enable targeting of coverage to meet local needs and conditions.

Encourage greater recipient enrollment in HMOs—Health maintenance organizations are one of the most effective and positive arrangements for the economical delivery of services. However, there are some provisions which unduly limit their utilization under Medicaid.

Federal law limits an HMO's enrollment to 50 percent from Medicare and Medicaid after three years of operation. This barrier was imposed in response to some problems in 1972 with California prepaid health programs being too heavily enrolled with Medicaid recipients. Subsequent legislative safeguards and changes in HMO practices have largely removed any need for this policy. States would like for the HHS Secretary to have authority to waive the enrollment limitation for HMOs in medically underserved areas.

Another problem is that the recipients unrestricted choice of providers enables a very high turnover of Medicaid enrollers in HMOs (as much as twice the non-Medicaid enrollees), thus discourage marketing by a plan. Limitations on a recipient choice of providers or providing a guaranteed period of premium payment would ease this marketing problem.

Permit broader use of economic incentives and disincentives for service utilization.—States would like the flexibility to discourage unnecessary utilization of services and use of services in inappropriate settings (e.g. routine care in hospital emergency rooms). Currently, cost-sharing is only allowed for optional services and for medically needy recipients. States should have the added authority to levy nominal cost-sharing (deductibles, co-insurance, and co-payments) on mandatory services to the categorically needy. Cost-sharing should also be allowed for selected services, diagnostically related groups, and provider settings.

It must be mentioned that proposals to require cost-sharing should be rejected. The imposition of cost-sharing should be left for state adaptions.

Conversely, states should have the option of sharing savings from cost-effective services with a recipient in the form of expanded benefits, extended eligibility, or cash payment.

Permit family supplementation of nursing home costs.—Despite state laws about family responsibility for nursing home expenses, supplementation is effectively prohibited by court decisions and Supplemental Security Income policy. There is a belief that policies need to allow a reasonable supplementation for the nursing home care of a family member. The purpose of this provisions would be to discourage institutionalization where family supports exist and to simply save Medicaid money. Voluntary contributions could either be made to a special nursing home financing fund or to the providing facility.

Provide authority to terminate recipients who abuse the program.—Under present law, recipients who are convicted of program fraud or who abuse the program by chronic and willful overutilization must be allowed anyway to receive Medicaid benefits as long as they meet eligibility requirements. Currently, only providers may be subject to suspension or termination from the program. States should also have sanctions, including eligibility termination, available to impose on recipient abusers.

Simplify eligibility determinations.—In general, Medicaid eligibility requirements are unmanageably complex. Three particular problems are the spend-down provisions in the medically needy program, determination of the personal needs allowance for institutionalized recipients, and extensions of eligibility to some recipients for three months prior to application and four months after AFDC termination.

Give states responsibility for utilization review of Medicaid services.—The process of reviewing the medical necessity and appropriateness of services is essential. However, professional standards review organizations (PSROs) in many areas simply replaced successful state utilization control programs. States are concerned that PSROs do not have fiscal responsibility for their decisions and even more so about the delegation of review to hospitals. To facilitate decisions consistent with state needs, the states would like a restoration of their authority to review and

control utilization. At the very least, states would like to have the PSRO's flexibility to do focused review.

I would like to bring to your attention, also, two areas in need of strong legislative oversight—the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program and long-term care.

Deregulate EPSDT.—Current EPSDT regulations place heavy emphasis on administration processes to the detriment of the goal of delivering health services. The penalty requirements distort the program's goals and increase a state risk in serving difficult to reach children. The most frequently heard recommendation of state Medicaid directors is that process-oriented regulations and penalty requirements be repealed.

The program operates without consideration of existing, effective health delivery systems and the unique needs of different areas. Benefits have been expanded for such services as orthodontics without regard to state priorities. States should have the authority to develop their own child health strategies. The program should be developed to complement, not replace, other children's health services available in the state.

Simplify regulation of nursing home care.—The most important issue here is the completion of the study on facilitating dual certification for skilled nursing facilities under Medicare and Medicaid. The study was required to be conducted in one year by HHS as part of last year's reconciliation bill.

We welcome President Reagan's proposal to certify skilled nursing facilities for a period longer than the present 12 months. This will relieve an unnecessarily heavy burden on state survey programs.

Other areas for attention are the definitions of institutions for mental disease, the restrictive regulations for intermediate care facilities for the mentally retarded, and the meaningless process of physician recertification of the services needed for long term nursing home residents.

There are two program changes proposed by President Reagan which we must oppose: accelerated collection of disputed Medicaid expenditures and repeal of the one year time period, 1981, for states to enter or modify agrrements to "buy-in" Medicare Part B. On both issues, the reconciliation bill conference committee crafted reasonable compromises which should not be overturned.

The American Public Welfare Association is currently under contract with the Health Care Financing Administration to survey state Medicaid directors about federal statutory and regulatory provisions which act as barriers to more efficient Medicaid program operation. The project will conclude next month. The project is a valuable opportunity to specify problem areas. The final results, and to the maximum extent feasible, preliminary findings, will be presented for your consideration soon.

We look forward to working with you in considering Medicaid changes and stand ready to assist you in whatever way we can.

Senator DURENBERGER. Our next panel is Mr. Robert Stone, chairman, Hospital Association of New York State; president of Blythedale Hospital, Valhalla, N.Y. He is accompanied by Monsignor James Fitzpatrick, Albany, N.Y., who is vice president of the Hospital Association of New York State.

And, Mr. Larry S. Gage, president, National Association of Public Hospitals, Washington, D.C.

Larry, it is nice to have you back again.

Welcome, Mr. Stone, you may proceed with your testimony.

STATEMENTS OF ROBERT STONE, CHAIRMAN, HOSPITAL ASSOCIATION OF NEW YORK STATE; PRESIDENT, BLYTHEDALE HOSPITAL, VALHALLA, N.Y, ACCOMPANIED BY MSGR. JAMES FITZPATRICK, ALBANY, N.Y., VICE PRESIDENT, HOSPITAL ASSOCIATION OF NEW YORK STATE, AND LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, WASHINGTON, D.C., ACCOMPANIED BY ROBERT JOHNSON, EXECUTIVE DIRECTOR OF D.C. GENERAL HOSPITAL

Mr. STONE. Thank you, Mr. Chairman.

I am Robert Stone, chairman of the board of trustees of the Hospital Association of New York State and the executive director

of Bylthedale Children's Hospital in Valhalla, N.Y., which is a children's rehabilitation center for handicapped children where we have 75 percent covered by medicaid.

The Hospital Association of New York State represents over 300 not-for-profit acute and long-term health care institutions in New York State.

In the interest of time, I will briefly summarize our prepared statement, but I request that our full testimony be included in the hearing record.

Let me say at the outset, Mr. Chairman, that we very much appreciate this opportunity to appear before the committee and share with you our views and recommendations on the administration's proposed health spending reductions for fiscal year 1982.

While we have attempted to analyze these proposals carefully, our efforts were limited to broad considerations because of the specific legislative proposals on which major portions of the proposed budget are based were not available to us.

We would like the opportunity to comment in more detail on such legislation when it is considered by this committee.

We join the President and the Congress in the hope that the state of the Nation's economy can be improved by the policies outlined in the administration's plan for economic recovery. We are all victims of the rampant inflation which is eroding our standard of living and putting more and more of our citizens at risk for the basic necessities of life.

Government spending and tax policy must be changed and we support the thrust of the administration's plan to reduce Federal spending and to encourage growth and productivity in the private sector.

As health care providers, we are acutely aware of the consequence of double-digit inflation and rising unemployment.

Without restating the various reasons for the present crisis in the health care financing, suffice it to say that the burden is placed on the two major public health financing programs, medicare and medicaid are increasing much more rapidly than the resources available to support them.

We agree that cuts in the rates of increase in spending for these programs must be achieved. While we support these objectives, we are concerned that specific actions to implement them should be taken wisely because false steps may put the entire strategy into question.

The fact is that we take specific exception to some of the proposed means for achieving these goals for the health function 550, an area in which we have considerable knowledge and experience.

In our statement, we have sought, first, to provide a context for understanding and analyzing the medicaid program.

Then, we recommend a series of fundamental principles to be applied in the process of adopting spending cuts.

Lastly, adhering to these principles, we critique the administration's proposal and provide our recommendations for legislative change.

The principles we recommend to the committee are, one, that savings should be obtained from sources that can realistically and equitably bear the burden.

Two, that changes made in fiscal year 1982 avoid unnecessary risks and be consistent with the future direction intended for health care systems.

And, three, that a stable health care system be established now and in the future to assure proper transition without unacceptable disruption in service to the poor.

Applying these principles, we recommend that the committee take substantially less savings from medicaid substituting selected medicare cost-sharing alternatives such as listed in page 70 of the committee's fiscal year 1982 report under the Budget Act, together with one or more of the tax revenue proposals listed on page 71 of that report.

We also recommend that care be taken to provide essential rights of due process for those affected by changes made in title XIX, especially changes made by secretarial waiver that certain provisions of title XIX, including reasonable cost not be waived or amended.

In this regard, we urge that freedom of choice provision in title XIX should be amended with great sensitivity, balancing the need for fiscal restraint with proper concern for the needs of the poor.

Lastly, we urge close scrutiny of the formula used to allocate Federal medicaid expenditures to assure that States with either deteriorating economies or good cost containment track records are not unfairly penalized.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much.

Larry, I don't know, so I introduce earlier your associate, who I understand is Robert Johnson, D.C. General Hospital.

Mr. GAGE. Yes.

Senator DURENBERGER. Bob, welcome to the panel.

Larry, would you proceed?

Mr. GAGE. Thank you, Mr. Chairman, Senator Long.

My name is Larry Gage and I am president of the National Association of Public Hospitals. I'm accompanied this morning by Robert Johnson, who is executive director of D.C. General Hospital, who was able to fit the hearing at the last minute into his busy schedule, and he will be able to comment on the specific problems that individual public hospitals face.

In my prepared testimony this morning, which I will briefly summarize, I make four points which are relevant, I believe, to your consideration of the administration's medicaid cap and other health care budget proposals.

First is that the one consistent element in our health care delivery system in most metropolitan areas today is the public hospital system.

These hospitals are unique in several respects. First, they already receive a significant portion of their revenues from city, county and, in some cases, nonmedicaid State sources.

In addition, they also provide many essential services to all people who live in their areas of operation, not just the poor.

Moreover, these hospitals also train nearly half of all medical and dental interns and residents trained in the country. In cutting the Federal health budget, we believe it is essential that you do not damage the important and unique role of these institutions.

Second, any new medicaid flexibility Congress chooses to adopt will inevitably take longer for the Federal Government to implement and save less money in the near future than the administration suggests.

These changes, whatever their substantive nature and we haven't yet seen the administration's bill—will be changes in statutory rights, both of States and of beneficiaries.

States may require their own statutory changes. Even if accomplished entirely through waiver authority, we can expect substantial administrative delays and conceivably legal challenges by various parties. For this committee to rely on this flexibility for significant short-term savings in fiscal 1982 would, therefore, be a mistake.

Third, and I would refer you to the charts that I brought with me today which were the best and most accurate we could come up with, based on the available administration information, even if Congress can enact medicaid legislation and the administration produce regulations by October 1 if an arbitrary cap is included, most States will find short-term savings only through the most simplistic cuts in eligibility, benefits, or provider payments.

For urban public hospitals, the results could include a shift of many of their current patients from medicaid to so-called free care status.

In addition, while some private hospitals might pick up part of this new free care load, many newly ineligible patients will simply be dumped on the public hospital stoop.

In addition, they will be getting less money in many cases for patients they continue to serve under medicaid, and the real result will be significant demand for new city or county revenues to replace medicaid losses.

Where those revenues cannot be found, public hospitals will be forced to curtail or eliminate services, or postpone needed maintenance or renovation in order to pay for this additional free care.

Finally, we agree with the committee that the goals of health cost containment in medicaid reform are clearly appropriate.

But Congress must rely on the reforms themselves to save money rather than on arbitrary caps, and these reforms must include medicare, as well as medicaid.

If additional short-term savings are required, we believe the committee can and should look for better ways to achieve them and as an association, and speaking for the members of the association, we would be delighted to help you come up with some additional ways in medicare and medicaid. We will prepare a list, which we will submit over the next few days and we will continue to work with the committee in this regard.

Thank you.

Senator DURENBERGER. Thank you very much.

Mr. Stone, in your prepared statement you talked about not changing the reimbursement concepts that we're using, particularly for acute care services, but I guess I've been under the impression that a lot of hospitals in the country have been—and some previous witnesses here have testified in favor of prospective reimbursement?

Is there a distinction between acute care services and others for some reason or other, or what is your position on prospective reimbursement?

Mr. STONE. Well, we have been living with prospective reimbursement in New York State for quite some time, and all in the hospitals in New York State are in significant financial problems. There is nothing per se that is wrong about prospective reimbursement if it is handled in an equitable fashion. If prospective reimbursement is a mechanism for just arbitrarily providing a hospital with inadequate financing to do the job, obviously, we could not support that.

We think that prospective reimbursement could be studied and carefully analyzed, and we think it can be made to work, but it has to be on an equitable basis.

Senator DURENBERGER. That sounds a bit like your statement with regard to the elimination of freedom of choice where you talk in terms of needing some sensitivity.

I am curious to know where that sensitivity—that responsibility for that sensitivity is best placed. Is it in policy changes we make here? Is it in State government, or is it somewhere in the marketplace out there?

Mr. STONE. The problem with respect to freedom of choice, Senator, is that frequently people—and certainly, I think, it is true about medicaid beneficiaries, choose hospitals on the basis of geography more than anything else.

And if freedom of choice inhibits the ability of a beneficiary to receive care in an accessible hospital or receives care in a second-class hospital, or of poor quality, we would find that a highly undesirable feature. But we think that there can be some examination of the issues of the freedom of choice and there can be some regulations made on that.

Whether those have to be done here in Washington, or whether they have to be within the States, we think we have to study that a little bit.

The key issue, it seems to me, is the issue of accessibility at quality service, and within that framework, we think that there is room for freedom of choice.

Senator DURENBERGER. Thank you.

Larry, just so that I know it's the same Larry Gage who was here last year, could you explain the difference between the cap on hospital revenues and the cap on medicaid?

Mr. GAGE. Well, Mr. Chairman, I just happened to be present last week, I guess it was, when David Stockman was testifying and Senator Bradley, in fact, asked him that precise question. And as he is always well able to do, he provided a long-winded answer that really was only half of the truth.

Senator DURENBERGER. Are you going to shorten your wind and get to the truth.

Mr. GAGE. Yes. [Laughter.]

I think there is one similarity, from the point of view of Congress. This committee rejected the Carter administration cost containment proposal because it was an arbitrary cap on hospital reimbursement which did not tell the hospitals how to work within that cap. The same thing is true for States with the medicaid cap.

This cap tells all States they will have to save a certain amount of money without differentiating between efficient and inefficient States, and I think in that respect it is quite analogous to early versions of the across-the-board cap on all hospital costs.

I would say that an across-the-board cap on all hospital revenues is far more equitable than a cap only on medicaid, however. In fact, in talking with a number of the hospitals in the association, they agree that an across-the-board cap would be a far more equitable way to save money for the health care system and will prevent shifting of costs on to other payers and other institutions.

Mr. Johnson, would you comment on that?

Mr. JOHNSON. Mr. Chairman and Senator Long, I guess my concern about a cap comes from the perspective of a hospital that has a significant dependence on medicaid and since we don't have any place to pass along the cost to, as private hospitals have some margin of benefit to at least raise their charges and expect possibly to receive payment from those able to pay, public hospitals really have no place to pass the cost on.

If you assume that nothing is free; that all costs must be borne by someone, having a cap is artificial and, therefore, really puts unfair burden on the hospitals that provide the care—most of the care to the poor and, therefore, penalizes those who have assumed that responsibility or mission, or are mandated by law to do so. There must be a way to meet the health needs of the entire population and to attempt to control cost to some degree.

I am a believer that the approach of incentives to all, that is, incentives to the providers and incentives to the consumer, incentives to third-party payers is the approach to find that common ground where we all can come together and benefit from lesser cost care.

But I think in the reality of day-to-day operation of an institution, there are tremendous demands to provide more services, better services and all that means more cost and not less cost. So, I think, the question is: Where do we find that middle road that provides incentives for individuals to behave in a way that is more cost effective.

Senator DURENBERGER. Thank you very much.

Senator Long.

Senator LONG. Thank you, Mr. Chairman.

Mr. Gage, maybe you or one of the other witnesses can answer what I might have in mind here.

When you add up what is being paid for hospital care on a private prepaid basis, and then you add medicare and then you add medicaid, what percentages of all hospital care does that amount to?

Mr. GAGE. Well, when you say on a prepaid basis——

Senator LONG. I mean, private insurers and group health plans, and all that.

Mr. GAGE. I would like to—I can respond on behalf of several of the hospitals in our association. I think that they have a very unique situation, however, and I think that perhaps the private nonprofit hospitals have a different situation. In the case, for instance, of Boston City Hospital with a total budget of $102 million, private insurance and self-pay comes to about $12 million, or 12

percent, medicare pays for 21 percent; medicaid pays for about 29 percent and the city, county, and State appropriations outside of those programs pays for the rest, 39 percent.

Bob, did you want to comment on behalf of D.C. General?

Mr. JOHNSON. We have fairly similar breakdowns. Approximately 26 percent of our patients have medicaid; about 25 percent have medicare; something less than 8 percent have Blue Cross, commercial insurance, and other forms of third-party payer, and approximately 40 percent of the operating budget of the hospital, D.C. General Hospital, is borne by the District of Columbia government through a direct appropriated subsidy. In fact, of the population that we care for, probably closer to 45 percent are uninsured, but the subsidy covers about 40 percent of our costs—40, 41 percent.

Senator LONG. Here is a thought that strikes me and I just wonder if this is perhaps one alternative way of looking at it, keeping in mind that I didn't create any of this problem, but I am going to live with it just like you are. I've beeen voting to provide more medical care down through the years. Now, we are asked to cut back to save some money and to look at all the different programs and see where we can save some.

Some of the insurers made the point that appears to go to catastrophic care many times that most of that problem would be solved if we required the companies to find a way to do it, because there are ways you could do it with taxes, policies, and other ways. The catastrophic thing would be insured first ahead of these other costs that people might be better in a position to bear.

Now, I'm led to believe that about 90 percent of hospital care is paid on a prepaid basis by Federal programs, medicaid, private insurers and patients. The other 10 percent is paid by State and local agencies.

It seems to me though if we just target that 90 percent where we ought to target it, certainly in the voluntary area, the States and counties ought to be able to take care of the other 10 percent.

Mr. JOHNSON. Senator Long, if I could just respond. It is my understanding that approximately 20 million people in this country have absolutely no insurance, hospital or health insurance. About another 23 million have inadequate insurance and there lies the problem. That is, and many of those individuals may be financially indigent, but not categorically qualified for medicaid by virtue of either not having dependent children, or being categorically qualified disabled, or blind, or aged. So, that large 43 million people is where the problems lies, and I think that is part of the problem. That is, the fact even some people who are employed are not insured, represents a good part of the problem of people who need some form of assistance for financing their health care.

Senator LONG. Well, here is a table, for example, as shown me by one of our staff members, indicating the percentage distribution of who is responsible for the Nation's personal health expenditures. For hospital care, all but 10.7 percent of the expenditures are paid by the Federal Government, medicaid or private sources. The chart that is shown me in this publication here is from the social security bulletin, a Government publication. If the prepaid amount for hospital care is that high—90 percent—you would think that if we could target this public and insurance spending in the areas where

people ordinarily could not pay, you would think certainly that the system could carry that.

Mr. GAGE. Senator Long, I believe the chart you are referring to comprises the universe of the people who pay or who receive care and who pay for their care. Of that population, 95 percent, or whatever, is paid for by third-party programs, whereas 5.5 percent pays for themselves. I think that leaves out a large number of people who, in fact, don't pay anything, who either go to the public hospitals or who are picked up by private nonprofit hospitals as uncompensated care or bad debts.

I think the point to make is that under our current system today, we have what I might call a closet national health insurance program. There are very few people in the country who actually fall through the cracks and don't receive acute care when they have a medical emergency.

There are an awful lot of them who never get preventive care; who never get care that would keep them from needing acute care later in their lives, but these are paid for, as I pointed out, in public hospitals, where as much as 40 percent of the tab is now picked up by city, or county revenues or in some cases, State revenues. With regard to private nonprofit hospitals, I think you should receive a response from the New York witness about other ways in which it is picked up, or shifted to third-parties, or simply absorbed.

Mr. STONE. Senator, in New York State, the figures we have for 1979, 42 percent of the patient days were covered by medicare; 23 percent by Blue Cross; almost 17 percent—16.7 percent medicaid, and the remaining were made up with workers compensation, commercial insurance, self-pay and free patients.

So, the vast majority, actually greater than 50 percent in New York State were either medicare or medicaid payment in 1979.

Senator LONG. Now, I haven't made up my mind what my position on this ought to be. I'm listening to witnesses and learning from you and trying to decide what I ought to do about it.

I know in Louisiana where we have always had a very big program, we could save a tremendous amount of money if we really went to work and required those people who are obtaining free medical care, and who can pay, to pay for it.

For example, the time I look back and think in terms of all the people we're treating in our public hospital systems and those who could have paid, frankly, my impression is that about half of them could have paid something.

I recall one time in a political campaign, and being on the side that's always been for providing care for the poor, our side would actually go out and hold up some bills that the State was paying without ever for a moment discussion with the person whether he might have been able to pay something. But if we really insisted on bearing down on it, I think that there are a lot of people in our State, and I think in most other States, who could be expected to pay for care that they now get free of charge.

Would you say that in New York that you don't have a lot of people coming in and getting service at Government expense who could pay if you really had to find some money somewhere?

Mr. STONE. Well, I don't think that there is a great number of people that could pay. I would certainly endorse the concept that if somebody can pay, they should pay. I certainly would not want to be in a position of saying otherwise. However, the concept of coinsurance or the concept of partial payment is frequently ended up meaning that the hospital has a nice piece of receivables that it will never be able to collect on. But the fact of the matter is that particularly in medicaid coverage of ambulatory care is extremely difficult to get partial payment, most particularly around the working poor.

And adding the medicaid recipient to that is probably just going to deceive the problem because it is just going to mean that the hospitals are going to be in greater jeopardy on this.

Mr. JOHNSON. Senator Long, if I could just add a comment to it. Just to give you an example. When given the incentive to collect, District of Columbia General Hospital used to have a totally appropriated budget and because of a Local Law that is set aside as an independent entity within the District Government, over the past 4 years we have changed the proportion of collection where we used to collect approximately 34 percent of our operating budget, we are now collecting 57 percent. And the proportion of the District's contribution has gone down in reverse proportion as well. So, I think, there are opportunities where that exists, but I would suggest that we probably have gone to the limit. That we are maximizing probably the collection from medicaid and medicare and Blue Cross because we benefit from it. That is, we are able to upgrade the institution because of having additional cash collections to do so.

But I would also just make the point that within Washington, D.C., of the 14 hospitals, even though we provide over $30 million worth of uncompensated care, the other private hospitals in the city provide over $50 million collectively of uncompensated care. So, there are a lot of people within this jurisdiction that simply cannot afford to pay for the their services.

Senator DURENBERGER. That last statement may be an indication that part of the answer of the issue we were exploring earlier in terms of incentives lies in the fact that locally collected taxes provide a substantial incentive to pull together some of the things we've been asking about here in terms of discipline on the system.

Mr JOHNSON. Even though I think Washington, unfortunately, is probably at the point of some financial difficulties that go much deeper in its deficit to finance some of these problems, and I suspect other cities are in better shape financially, but many are in similar shape, or will be soon. So, I'm not sure at the local level there is much additional tax monies to draw from, heavily taxed citizens.

Senator DURENBERGER. Monsignor Fitzpatrick, let's give you a chance to summarize your observations before we excuse the panel.

Msgr. FITZPATRICK. Thank you, Mr. Chairman.

I would like to return for a moment, Mr. Durenberger, to the topic of freedom of choice. I think what we are espousing, of course, we feel that there is a tremendous amount of duplication of care, a lack of continuity of care, which is efficient delivery of care, I might add, in the way freedom of choice is presently exercised.

What we are recommending, sir, is that basically a medicaid recipient would have the freedom of choice to designate a provider for a specific period of time so there would not be a duplication of laboratory, of X-ray, and a whole series of other things that add immeasurably to the cost of the medicaid program, especially in the ambulatory care side.

They shop a bit; they go around; they go around from one place to another place and this is what we are talking about when we say that there should be some limitation on the freedom of choice, not denying freedom of choice to the poor, and having them make a judgment on where they want to get their care and save their money through the efficiency of delivery and the lack of duplication of services.

Senator DURENBERGER. Thank you for that statement. And before I pass you all off to the chairman of the committee, I would like to accent what we've said here earlier in terms of getting your more specific recommedations on changes in medicare.

We obviously want to stay within the limitations that are going to be provided to us this week on the floor of the Senate, but we also want to do it right, and that is the purpose of these hearings, and, particularly we need your advice on the specifics.

The list on page 70 and 71 were sort of a summary of a variety of suggestions that have been made, but they're put there primarily to encourage you to respond with your own suggestions and perhaps some prioritization within those recommendations.

So, whatever you can get to us, and as soon as possible, we would appreciate it.

Senator DOLE.

The CHAIRMAN. Senator Long, do you have any other questions at this time?

Senator LONG. No, Mr. Chairman.

The CHAIRMAN. I have no questions. I appreciate very much your testimony, and, as was indicated by others, we are looking for ways to comply with—maybe comply is not the right word, but we are looking for ways to save some money. The votes we have had these past days which indicate that the majority, probably in both parties, share that view.

So, if you can give us alternatives, we would appreciate it very much.

This committee has jurisdictions—Senator Long knows the pot of spending. I think it is $375 billion of the total budget. Take away the interest, that lowers it about $100 billion, but it is still a pretty good sum of money. We ought to be able to save a little out of that amount without doing violence to anyone.

Thank you very much.

Mr. STONE. Thank you.

Mr. GAGE. Thank you.

[Statements follow:]

STATEMENT OF THE HOSPITAL ASSOCIATION OF NEW YORK STATE

I am Robert Stone, Chairman of the Board of Trustees of the Hospital Association of New York State and Executive Director of the Blythedale Children's Hospital in Valhalla, New York. The Hospital Association of New York State represents over 300 not-for-profit acute and long term health care institutions in New York State. In the interest of time, I will briefly summarize our prepared statement, but I request that our full testimony be included in the hearing record.

SUMMARY STATEMENT

Let me say at the outset, Mr. Chairman, that we very much appreciate this opportunity to appear before the Committee and to share with you our views and recommendations on the Administration's proposed health spending reductions for fiscal year 1982. While we have attempted to analyze these proposals carefully, our efforts were limited to broad considerations because the specific legislative proposals on which major portions of the proposed budget are based were not available to us. We would like the opportunity to comment in more detail on such legislation when it is considered by this Committee.

We join the President and the Congress in the hope that the state of the nation's economy can be improved by the policies outlined in the Administration's plan for economic recovery. We are all victims of the rampant inflation which is eroding our standard of living and putting more and more of our citizens at risk for the basic necessities of life. Government spending and tax policy must be changed, and we support the thrust of the Administration's plan to reduce federal spending and encourage growth and productivity in the private sector.

As health care providers, we are acutely aware of the consequences of double digit inflation and rising unemployment. Without restating the various reasons for the present crisis in health care financing, suffice it to say that the burdens placed on the two major public health financing programs—Medicare and Medicaid—are increasing much more rapidly than the resources available to support them. We agree that cuts in the rates of increase in spending for these programs must be achieved.

While we support these objectives, we are concerned that specific actions to implement them should be taken wisely because false steps may put the entire strategy into question. The fact is that we take specific exception to some of the proposed means for achieving these goals for the health function 550 an area in which we have considerable knowledge and experience. In our statement, we have sought first to provide a context for understanding and analyzing the Medicaid program. Then we recommend a series of fundamental principles to be applied in the process of adopting spending cuts. Lastly, adhering to these principles, we critique the Administration's proposal and provide our recommendations for legislative change.

The principles we recommend to the Committee are: (1) that savings should be obtained from sources that can realistically and equitably bear the burden; (2) that changes made in fiscal year 1982 avoid unnecessary risks and be consistent with the future direction intended for the health care system; and (3) that a stable health care system be established now and in the future to assure proper transition without unacceptable disruption in service to the poor.

Applying these principles, we recommend that the Committee take substantially less savings from Medicaid, substituting selected Medicare cost-sharing alternatives, such as listed on page 70 of the Committee's Fiscal Year 1982 Report under the Budget Act, together with one or more of the tax revenue proposals listed on page 71 in that Report. We also recommend that care be taken to provide essential rights of due process for those affected by changes made in Title 19, especially changes made by Secretarial waiver, and that certain provisions of Title 19, including "reasonable cost," not be waived or amended. In this regard, we urge that the freedom of choice provision in Title 19 should be amded with great sensitivity, balancing the need for fiscal restraint with proper concern for the needs for the poor. Lastly, we urge close scrutiny of the formulae used to allocate federal Medicaid expenditures, to assure that states with either deteriorating economies or good cost containment track records, are not unfairly penalized.

FULL STATEMENT

Let me say at the outset, Mr. Chairman, that we very much appreciate this opportunity to appear before the Committee and to share with you our views and recommendations with respect to the Administration's proposed health spending reductions for Fiscal Year 1982. While we have attempted to analyze carefully these proposals, our efforts were limited to broad considerations because the specific legislative proposals on which major portions of the proposed budget are based were not available to us. We would like the opportunity to comment in more detail on such legislation when it is considered by the Committee.

All of us share with the President and you in the Congress a fervent hope that the state of the nation's economy can be improved by the policies outlined in the Administration's plan for economic recovery. We are all victims of the rampant inflation which is eroding our standard of living and putting more and more of our citizens at risk for the basic necessities of life. Government spending and tax policy

must be changed, and we support the thrust of the Administration's plan to reduce federal spending and encourage growth and productivity in the private sector.

As health care providers, we are acutely aware of the consequences of double digit inflation and rising unemployment. Without rehearsing the various reasons for the present crisis in health care financing, suffice it to say that the burdens placed on the two major public health financing programs—Medicare and Medicaid—are increasing much more rapidly than the resources available to support them. We agree that cuts in the rates of increase in spending for these programs must be achieved.

While we support these objectives, we are concerned that specific actions to implement them should be taken wisely because false steps may put the entire strategy into question. The fact is that we take specific exception to some of the proposed means for achieving these goals for the health function 550 an area in which we have considerable knowledge and experience. In our statement, we have sought first to provide a context for understanding and analyzing the Medicaid program. Then we recommend a series of fundamental principles to be applied in the process of adopting spending cuts. Lastly, adhering to these principles, we critique the Administration's proposal and provide our recommendations for legislative change.

Changes in Title 19 cannot be discussed without an understanding of certain facts about Medicaid. First, Medicaid is a program in which the majority of expenditures are made in a relatively few urban industrialized states. Only ten states, including New York, California, Michigan, Ohio, Massachusetts, Illinois, account for approximately 60 percent of total expenditures. Approximately 40 percent of all Medicaid expenditures are made for long term care; acute hospital care accounts for approximately 30 percent of Medicaid outlays. Hospital expenditures are in turn concentrated in relatively few hospitals typically located in core urban areas. In New York, for example, only 26 of 284 community hospitals provide more than 50 percent of all Medicaid days of inpatient care.

Another important point is that inflation in Medicaid expenditures in recent years has been subjected to state initiated cost containment efforts that have already saved the federal treasury billions of dollars. The social cost of this effort has been substantial, however, leading to deterioration of Medicaid's effectiveness particularly in making acute care available to the poor. In New York, the hospital industry suffered an operating deficit in 1979 in excess of $250 million. Since 1975, operating losses have exceeded $1 billion. Losses of this magnitude have forced bankruptcy, closure or debilitation of numerous hospitals, especially among those with heavy responsibilities for Medicaid patients. A closely related aspect of the deterioration of Medicaid as an effective program is that a relatively smaller number of poor people are eligible for Medicaid now than in 1975; and many of the poor excluded from the program cannot afford private insurance. In New York, for example, bad debt and charity care losses incurred by hospitals amount to some $330 million a year.[1]

What is suggested by these points is that Medicaid, especially for acute care, has already been subjected to severe cost constraints; that the burden of these on any future cuts in Medicaid are borne by relatively few states and, in those states, relatively few hospitals; and that cuts already effected in Medicaid have caused a severe deterioration in the program, reducing the access of the poor to decent hospital care. We suggest to the Committee that the problems posed by the increases in Medicaid expenditures are complex problems. Necessarily, the solution will not be simple. Accordingly, changes in the Medicaid program must be approached with sensitivity. It is from this vantage that the Association has analyzed the President's proposal for savings in health function 550.

Our analysis has proceeded on the basis of three principles, which we commend to the Committee as providing a proper basis for budget reductions. The first principle is that savings should be obtained from sources that can realistically and equitably bear the burden. If this principle is not followed, then there is a risk that paper savings may not in fact be achieved or, alternatively, may be achieved only through unanticipated and unnecessary hardship beyond what Congress or the Administration intended. The second principle we urge is that changes made for fiscal year 1982 avoid excessive risks, and be consistent with the future direction intended for the health care system, recognizing the present limits of our knowledge about the most effective design for our health delivery system. Lastly, we believe it essential to stabilize the health care system now so that it can accommodate needed change,

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[1] The statistics in this paragraph do not include the deficits incurred by the Health and Hospitals Corporation in New York City—a major Medicaid provider. The Health and Hospitals Corporation deficits over 1975-1979 aggregated more than $1.8 billion.

but on an incremental basis, so that change is achieved without unacceptable disruptions in service to the poor.

Applying these three principles to the Administration's proposal for savings in the health function 550, as it has so far been presented in the fiscal year 1982 budget documents, the Association believes the proposal is deficient in several respects. First, and most important, we do not believe that the Medicaid program is a realistic or equitable source for the level of savings in fiscal year 1982 contemplated by the budget.

The billion-dollar slash—more than 5 percent of program outlays—estimated for Medicaid is unduly severe. However, this figure is based on an assumed current budget increase of only about 10.5 percent. If inflation in health costs were estimated more accurately at 13 percent for 1982, the cut resulting from limiting the increase to 5 percent would yield a cut of about 8 percent from Medicaid in real terms on a national basis. In individual states which experience above-average inflation or which have increases in the eligible population, their ability to care for the truly needy would be significantly impaired. The potential impact of the possibility—perhaps likelihood—of higher inflation than assumed in the light of a 5 percent limit should not be dismissed lightly.

While we agree that some Medicaid savings can be achieved in fiscal year 1982, and additional savings in future years, the Administration's target is too high. Instead, serious consideration should be given to several alternatives already outlined in the Committee's Report for 1982 under the Congressional Budget Act.

Medicaid savings obtained by limiting federal expenditures must come from three possible sources. Either providers can cut their cost of services or states can change their Medicaid programs so as to pay less for services, or to reduce eligibility or benefits, or states can pay for the shortfall in federal contributions out of general state and local tax revenue.

Unfortunately, the most promising of these potential sources are unlikely to produce significant savings in fiscal year 1982. It is not reasonable or prudent to assume that the provider community in fiscal year 1982 will have a rate of inflation appreciably less than general inflation. This particularly true in those states that account for the largest share of Medicaid expenditures—like New York—because much of the potential cost-reducing change has already occurred. If future reductions of significance occur, they will have to come through more fundamental health system organizational reforms. Most proponents of new and arguably more efficient forms of health care organization recognize, however, that fundamental structural reform will take several years to achieve on a large scale. similarly, most states cannot be expected to implement dramatic cost-saving changes in state programs in the near future. Many states, especially those with large Medicaid responsibilities, have already been changing their programs to contain costs, in some cases for years. Additional large savings will not be obtained in these states during fiscal year 1982. Indeed, many states would need to amend state law which cannot be done until the State Legislature reconvenes next January or in January of 1983. thus, neither provider reorganization nor major state program changes are realistic sources of substantial Medicaid savings for fiscal year 1982.

It should be understood that cuts in benefits are not free. Either eligible poor people would be the source of savings by going without care, as a result of reductions in eligibility that increase the pool of non-paying patients, or through Medicaid payment reductions, providers would be required to pay the addition costs. But while the poor and providers can afford to shoulder some of the burden of federal savings, the Association does not believer that they can afford, either realistically or equitably, the full billion dollar burden proposed for Medicaid in the budget.

The remaining source of medicaid savings are state tax payers who could be asked to produce a federal budget savings. However, tax increases at the state level seem as unlikely as at the federal level. Ten states account for 60 percent of total Medicaid expenditures. Assuming the savings is distributed on this basis, they would account for over $600 million of the total. Yet almost without exception these states are already experiencing severe economic distress as revealed in various indexes of economic condition. New York's flirtation with bankruptcy is well known. Michigan and Ohio have unemployment in excess of 10 percent. Massachusetts and California have imposed limits on their rates of taxation. The taxpayers in these few troubled states simply cannot take on the disproportionate burden of the full proposed savings in Medicaid.

Needless to say, most Medicaid beneficiaries are the poorest of the poor. They cannot bear further loss of benefits. As for Medicaid providers of hospital care in the heavy Medicaid states, their situation has already deteriorated to a level of genuine crisis. Not the least of the causes of this crisis is the considerable burden of cost containment they already shouldered and the significant costs of providing

needed care for the growing number of unsponsored patients. In New York, our most recent survey of the financial condition of our institutions reveals that 80 percent operated at a deficit in 1979, including the major Medicaid providers.

The Association does not suggest that the level of savings sought by the Administration overall in health function 550—some $2 billion— should not be maintained. Nor do we believe that some savings cannot or should not be taken from Medicaid. Incremental program and service delivery changes can be made and savings achieved. But there are additional sources of savings within budget function 550 that are, in our opinion, more realistically and equitably available. By adopting some of these alternatives, the level of savings from Medicaid can be reduced to realistic levels and the savings burden more equitably distributed without reducing overall savings in health function 550. For example, on page 70 of the Data and Materials for the Committee's Fiscal Year 1982 Report under the Congressional Budget Act, the Committee staff has listed several changes in the Medicare Part B deductible that could provide hundreds of millions of dollars in savings in fiscal year 1982. These savings would be achieved through imposition of very small additional costs on the many millions of Medicare beneficiaries. Asking those Medicare beneficiaries who are relatively well-off to contribute a few dollars each is certainly not unthinkable.

Another simple and equitable option would be to coordinate the benefits of employed Medicare beneficiaries with their employer's group health insurance, with the private insurance providing first dollar medical insurance coverage. Savings in excess of $200 million would be obtained from this proposal, through very small increases in group insurance premiums spread ultimately across a very large number of employers and the employed middle class.

A third and similarly equitable distribution mechanism would apply in the case of the tax revenue proposals listed by the Committee on page 71 of its Data and Materials. The Association also supports these proposals as realistic and equitable sources of savings in health function 550.

In short, Mr. Chairman, we believe it is possible to achieve savings in health function 550 that are consistent with those proposed by the Administration. We believe, however, that it is neither realistic nor equitable to seek savings of a billion dollars from the Medicaid program, especially when fair and reasonable alternatives are so readily available.

Applying our second principle, caution and consistency with future goals, the Association believes the Administration's proposal to provide enhanced flexibility to the states as outlined in the budget document gives reason for concern.

It is imperative, in the absence of acceptable alternatives, that the underlying purposes of Medicaid—provision of health care to the poor—continue to be served. Enhanced flexibility must not lead to premature dismantling of an essential service program. Moreover, providers and beneficiaries have developed through the years many legitimate expectations in reliance on Title 19. If the law is to be changed, and it must, it cannot be amended casually. The consequences of proposed changes for those who have properly relied on Title 19 in the past must be considered and fully understood.

Two provisions in Title 19 seem especially crucial. First, we believe that the concept of paying reasonable cost for acute care services should not be changed. There is much evidence that in every case in which reasonable cost has not been paid, fewer providers than are needed have been willing to participate in the program. In the case of acute illness, the incidence of which is uncontrollable, the social and health consequences of long queues of needy patients waiting to be treated by too few providers would be disastrous. Moreover, there is ample evidence that states have sufficient flexibility to modify reimbursement within the latitude of the existing reasonable cost provisions in Title 19.

A second sensitive provision in Title 19 is the so-called "freedom of choice" requirement, which was considered by this Committee last fall. The Association strongly supported the freedom of choice provision. However, we do not believe it necessarily must be left totally unchanged. On the contrary, the present provision may cause Medicaid eligibles to be less cost conscious in seeking care than is appropriate. For example, the Association would certainly endorse a program that requires eligibles to make a choice between accessible providers of quality service and then to stick by that choice for a specified period of time. Indeed, if such a limitation were accompanied by the guaranteed eligibility of the beneficiary for the established time period, such a provision would greatly enhance the ability of providers to plan for care. Certain types of Medicaid services such as laboratory services for outpatients and durable medical equipment and supplies are also examples of opportunities to achieve program savings in a reasonable manner.

On the other hand, an approach to freedom of choice that allows individuals to be sent to inconvenient, inaccessible, or poor quality institutions, offering the person no choices whatsoever, would be grossly undesirable. If the requirement is changed, it is important to assure that Medicaid eligibles be given proper access to good quality care and not simply consigned to a second class health delivery system.

The Committee should exercise sensitivity in changing these two provisions of Title 19, or indeed any provisions in that statute. On the other hand, if the Administration does not seek to change Title 19 in fiscal year 1982, but only to allow its provisions to be waived by the Secretary, then even greater caution must be exercised. Certainly neither the reasonable cost requirement nor an appropriately limited freedom of choice provision nor a mandatory minimum benefit package should be allowed to be waived. Moreover, certain minimum due process rights should be accorded, at both the state and the federal level, to any parties affected by a proposed waiver. As in the case of rulemaking—although perhaps more in this case because statutory rights are being abridged—providers, eligibles and others should be given formal notice of a proposed waiver, an opportunity to express views and to have those views considered, and a rational decision that is consistent with the purpose of strengthening Medicaid. Title 19 represents a national commitment to our poorest citizens that their medical care needs will be met. Waivers should be granted only if they further this purpose, and should otherwise be withheld. Reduced inflation in the cost of caring for the poor is appropriate; reduced care to those who are eligible and need it is not.

The third principle that the Association urges this Committee to adopt in responding to the President's proposals for Medicare and Medicaid in fiscal year 1982 is that such proposals serve to stabilize the acute care delivery system, and foster more efficient care for all our citizens including the poor. In regard to this principle, we feel that several steps might be taken by the Committee in legislation proposed for this year.

First, it may be appropriate for the Committee to consider whether the present federal formula for matching state expenditure under Title 19 properly takes into account the economic condition of the states, including both their levels of need and their capacity to finance. The states most inequitably treated now are those urban industrial states with high Medicaid populations, declining tax bases and rising unemployment. These states have in many cases experienced severe economic distress and the present formula for allocation of the federal share of Medicaid does not fully and fairly take account of this distress.

The Association would look forward to working with this Committee toward the identification of measures which fairly represent a State's capacity to finance medical assistance. Alternatively, even if the basic methodology for calculating the federal share does not change, we feel that any allocation of the limited federal dollars for medicaid should be done on the basis, among other things, of how well states have done in recent years in containing year-to-year inflation to medicaid expenditures. Using a 1981 base for calculating the cap rewards the profligate and penalizes those who have exercised restraint. Certainly it would be ironic to penalize New York or any other state for having contained the increase in medicaid costs to levels far below what other states have achieved and indeed far below the national average.

A second means for stablizing the health care system in the short run would be to create a special fund for distressed hospitals, perhaps through the accumulation of savings in health function 550 in excess of what the Administration seeks. This fund could be made available for payments to needed hospitals and other facilities that have reached a point of terminal financial distress. The need for such payments is dramatically illustrated by the bankruptcy or near closure in recent years of such vitally needed urban hospitals as Homer Phillips in St. Louis, Brooklyn Jewish, Metropolitan and Bronx-Lebanon in New York. Such institutions exist in every large urban area in this country, frequently in the neighborhoods that most need their presence. If these health care facilities could be saved through special federal funding, there would be a dramatic increase in the stability of the acute care system and in the ability of that system to meet the needs of the poorest and sickest of our citizens. In addition, the grant could be conditioned to require recipients to make desirable changes in the way care is delivered.

While the Association is very sympathetic to the concept of "competition" and "consumer choice," we are concerned that too little is now known about how to implement these concepts in practice: What types of organizational structures will be needed to assure efficient provider and beneficiary behavior, what tax and insurance machinery will be needed, how can we change behavior without undue regulation? The Association suggests that the Congress, anticipating the need for change and the Administration's intention to introduce its proposals for fiscal year

1983, establish a national commission to study these and the numerous related issues and to obtain further information about tax incentives, reimbursement techniques, insurance mechanisms, and other matters underlying these issues. Further, Health and Human Resources Secretary Richard Schweiker has recently indicated his desire to initiate demonstration projects testing the concepts of competition and consumer choice. These projects should be undertaken only on the basis of defined critera and controlled evaluation mechanisms subject to review by this Committee.

In summary, Mr. Chairman, the Association supports the goals of the Administration's budget. We believe, however, that the specific details of a legislative package should be considered carefully. To that end, we have offered a simply legislative program for the health area that would achieve the economic benefits sought by the President in that area while distributing the burden of savings more equitably and assuring continued access for the poor to high quality health care. We will look forward to working with the Committee on implementation of our proposals.

SUMMARY OF STATEMENT OF LARRY S. GAGE

Mr. Chairman, members of the Committee, my name is Larry Gage and I am President of the National Association of Public Hospitals. This new organization was founded late last year to provide a voice in national health care policy-making for our large, urban public hospitals—institutions which are the health "safety nets" in most of our metropolitan areas. In my prepared testimony this morning, I make four points relevant to your consideration of the Administration's health-care budget proposals:

1. The one consistent element in our health care delivery in most metropolitan areas today is the public hospital system. These hospitals are unique in several respects. First, they already receive a significant portion of their revenues from city, county, and non-Medicaid state sources. In addition, they also provide many essential services to all people who live in their area of operations—not just the poor. Moreover, these hospitals also train nearly half of all medical and dental interns and residents. In cutting the federal health budget, it is essential that you do not damage the important and unique role of those institutions.

2. Any new Medicaid "flexibility" Congress chooses to adopt will inevitably take longer for the Federal Government to implement, and save less money in the near future, than the Administration suggests. These changes—whatever their substantive nature—will be changes in statutory rights, both of states and of beneficiaries. States may require their own statutory changes. Even if accomplished entirely through waiver authority, we can expect substantial administrative delays and conceivably legal challenges by various parties. To rely on this flexibility for sigificant short-term savings in fiscal 1982 would be a mistake.

3. Even if Congress can enact Medicaid legislation and the Administration produce regulations by October 1 of this year, if an arbitrary cap is included, most states will find short term savings only through the most simplistic cuts in eligibility, benefits or provider payments. For urban public hospitals, the results could include a shift of many of their current patients from "Medicaid" to "free care" status. In addition, while some private hospitals may pick up part of this new "free care" load, many newly ineligible patients will simply be dumped on the public hospital stoop. The real result will be a significant demand for new city or county revenues to replace Medicaid losses. And where those revenues cannot be found, public hospitals will be forced to curtail or eliminate services, or postpone needed maintenance or renovation, in order to pay for this additional "free" care.

4. Finally, we agree that the goals of health cost containment and Medicaid reform are clearly appropriate. But Congress must rely on the reforms themselves to save money, rather than on arbitrary caps. If additional short-term savings are required, we believe the Committee should look for better ways to achieve them.

STATEMENT OF LARRY S. GAGE

Mr. Chairman, members of the Committee, thank you for giving me this opportunity to testify on the Administration's proposed Medicaid cap and other health-related block grants.

My name is Larry Gage and I am President of the National Association of Public Hospitals. This new organization was founded late last year to provide a voice in national health care policy-making for our large, urban public hospitals. We have approximately 20 member hospitals or hospital systems today, from 20 of our nation's most populous cities and counties. Far more than any single federal program, the institutions I represent are the health "safety nets" in our metropolitan areas—the providers of last resort, for the eligible medicaid recipient and illegal alien alike. In other words, the very existence of these large urban hospitals, funded

by state and local tax revenues, already provides a form of national health insurance in the cities and counties where they exist.

In my prepared testimony this morning, I would like to make four brief points which are relevent to your consideration of the Administration's health care budget proposals:

1. While our health delivery systems for the poor vary markedly around the country, the one consistent element in most metropolitan areas is the public hospital system. These hospitals are unique in several respects. First, they already receive a significant portion of their revenues from city, county and non-medicaid state sources. Thus, for many purposes they already labor under a "prospective budgeting" system. In addition, they also provide many essential services to all people who live in their area of operations—not just the poor. Moreover, these hospitals—fewer than 100 of the 7,000 in this country—also train nearly half of all medical and dental interns and residents. In undertaking to cut Federal expenditures for health, it is essential that you recognize and do not damage the important and unique role these institutions now play.

2. Any new medicaid "flexibility" Congress chooses to adopt will inevitably take longer for the Federal Government to implement, and save less money in the near future, than the administration suggests. These changes—whatever their substantive nature—will be changes in statutory rights, both of states and of beneficiaries. States may require their own statutory changes. Even if accomplished entirely through amendments to State plans, by giving the Secretary of Health and Human Services open-ended waiver authority, we can expect substantial administrative delays. Moreover, legal challenges by various parties to the final result may in many cases be inevitable. To rely on this flexibility for significant short-term savings in fiscal 1982 would be a mistake.

3. Even if Congress can enact Medicaid legislation and the Administration produce regulations by October 1 of this year, if an arbitrary cap is included, most states will find short term savings only through the most simplistic cuts in eligibility, benefits or provider payments. Such an approach will severely disadvantage the poor and the institutions that serve them. For urban public hospitals, the results could include a shift of many of their current patients from "Medicaid" to "free care" status. In addition, while some private hospitals may pick up part of this new "free care" load, many newly ineligible patients will simply be dumped on the public hospital stoop. And while part of this burden may be shifted to other payors, such as for Medicare eligibles, the real result will be a significant demand for new city or county revenues to replace medicaid losses. And where those revenues cannot be found, public hospitals will be forced to curtail or eliminate services, or postpone needed maintenance or renovation, in order to pay for this additional "free" care. In all likelihood, this process will thus destroy any realistic prospects for meaningful, long-term reform.

4. Finally, we agree that the goals of health cost containment and Medicaid reform are clearly appropriate. But Congress must rely on the reforms themselves to save money, rather than on arbitrary caps. If additional short-term savings are required, we believe the Committee should look for better ways to achieve them. You should look at Medicare as well as Medicaid, and you should also seriously consider cutting or slowing the rate of increase in our tax expenditures for health care. Even fairly minor changes in our health-related tax laws can greatly enhance the Committee's bottomline impact on the Federal deficit and begin to have long-range competitive effects as well. NAPH will be happy to assist you and your Staff in this process.

Let me elaborate on each of these points.

1. The health care delivery system for the poor in this country is as fragmented as you might expect in a nation where the federal government has consistently deferred crucial administrative and fiscal decisions to state and local governments.

One constant in this system in most large cities is the public hospital, owned primarily by local governmental entities, which serves as the hospital of last resort for all the poor, regardless of eligibility for governmental programs. It is important to realize that, while Medicaid differs markedly from place to place in the role it plays in financing health care for the poor, Cuyahoga County Hospital, for example, with over $100 million in total costs, received only slightly more last year from Medicaid ($24,323,886) than from local appropriations ($24,184,992). On the other hand, the Bexar County Hospital District, in San Antonio, with a total budget of $57 million, received just $3.8 million in Medicaid revenues last year, as compared with over $30 million in local tax support.

It is also important to note that, while some Medicaid programs may be relatively sound, many states are already implementing large cutbacks in Medicaid, even without a federal Medicaid cap, forcing public hospitals to contemplate significant

cuts. Los Angeles County, for example, may have to consider closure and sale of three of its seven hospitals, curtailment of out-patient facilities and transportation services, and refusal to accept many kinds of transfers from private hospitals.

Many public hospital systems also provide essential, specialized area-wide services to all the people—not just the poor. These often include around-the-clock emergency services, shock-trauma units, burn centers, poison control, drug abuse and alcoholism services, medical-social health programs, and high-volume ambulatory care facilities. Public hospitals are also the principal training grounds for our nation's physicians, training nearly half of all medical and dental residents in the country.

Finally, many public hospital systems often also run or coordinate closely with many Public Health Service Act programs, such as alcoholism and drug abuse treatment, community and migrant health centers, emergency systems, and maternal and child health programs. As a result, from the local perspective, the Medicaid cutbacks will be greatly amplified and exacerbated by short sighted cuts in those programs as well. At the very least, if the Congress enacts health block grants, you must also take the essential step of guaranteeing that such grants will be passed throught to those cities and counties which currently administer most of these programs. Otherwise, in addition to achieving the desirable goal of eliminating unnecessary overlap, we might also see a significant reduction in necessary, non-duplicative prevention, out-patient and other public health programs with far greater potential for long-range health cost containment than arbitrary caps.

2. There is little doubt the Administration could draft an overly simplistic Medicaid cap bill quickly and have it on the desks of the authorizing Committees by the end of this month, as they have indicated. All they would need to do is repeal most of the current state plan requirements in the name of increased flexibility, or perhaps give the Secretary of Health and Human Services some sort of blanket authority to waive any or all current Medicaid requirements.

However, as you will no doubt recognize even if you support every aspect of the President's plan, what is involved here is nothing less than a complete rewrite of the essential nature of Medicaid and other health programs which in some cases date back to the 1930s. When Congress takes a more responsible and less simplistic look at this proposal, I believe you are going to find more substantive problems than the Administration envisions. To give you a few examples:

How do you fairly and equitably apportion the effects of the cap among states whose support for Medicaid and previous record in holding down costs has varied so widely over the years?

If "flexibility" is to be accomplished through waiver authority, who will make these determinations? How much time will states have to make their requests, especially if they must also change their laws? Will there be time limits for Departmental decisions? How will due-process be protected in the event of an adverse determination on State's application for a waiver?

How do you determine (in a system involving millions of pieces of information) when the State or Federal limit has been reached? What do you do about state or federal funds inadvertently obligated in excess of the cap?

How do you design new systems which cost less and reduce the regulatory burden, but which nevertheless insure greater provider efficiency, more appropriate utilization, more careful eligibility determination, and less fraud and abuse, while guaranteeing protection of at least the basic rights of those who remain covered by the program?

As you can see, the issue is far more complicated than the Administration would have you believe. And at the very least, if true reforms are to result, time must be allowed for a careful legislative and regulation-writing process at the federal level. This is particularly true in determining whether this process is to be driven by an abritrary cap which would go into effect in a fiscal year that begins in just 182 days.

3. Even if Congress, by some legislative miracle, were to enact a Medicaid bill by this summer, its implementation by the states by the beginning of fiscal 1982 under an arbitrary cap would force most states to adopt crude "slash and burn" cost cutting techniques in lieu of sensible long-range reforms.

"Increased flexibility," with an October 1 deadline, will be a sham. Few states are prepared at this time to implement true Medicaid reforms. Instead, most states will simply reduce eligibility levels, eliminate benefits, adopt administratively burdensome copayments, or reduce payments to providers.

Further reductions in Medicaid eligibility levels or provider payments will simply shift more patients into "free care" categories. But there is no such thing as "free care." To the very limited extent private hospitals agree to absorb some of these people, they will pass the costs on to their private paying patients. And most of the rest of these patients will simply be dumped on the public hospital systems—and thus onto local, rather than Federal, taxpayers.

Some states may well figure out how to shift some of these costs back to the federal government, of course. For the 4 million or so beneficiaries eligible for both Medicare and Medicaid, for example, increased Medicaid deductibles or copayment can simply be written off as Medicare bad debts. Since Medicare pays for its own bad debts, the federal government will pay 100% of such costs rather than its relevant Medicaid share. But these techniques will pick up only a small part of the new costs. The rest of the burden will fall on local taxpayers often substantially involved already in the funding of care.

4. In summary, while Medicaid reform can produce savings and is a desireable goal, an arbitrary Medicaid cap will have a significant adverse impact on the poor and the "safety net" institutions which serve them. Certainly, there are problems with waste, duplication, and overregulation in our Federal health programs. We agree that some of these problems may well be susceptible to legislative solutions, and will try hard to help you find some of those solutions. We will also—as the governors suggest—help in your effort to provide considerably greater long-term flexibility in the Medicaid program. But simply shifting the entire health cost-containment burden at this time to local taxpayers and public hospitals through an arbitrary Medicaid cap—or indiscriminately "block granting" all categorical health programs with no determination of which ones are truly duplicative or in need of substantive change—will seriously impede any efforts for long-term rational reform.

The CHAIRMAN. Our next speaker is William Felch, vice chairman of the American Medical Association Council on Legislation.

STATEMENT OF WILLIAM FELCH, M.D., VICE CHAIRMAN, AMERICAN MEDICAL ASSOCIATION COUNCIL ON LEGISLATION, WASHINGTON, D.C., ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR OF AMA'S DIVISION OF LEGISLATIVE ACTIVITY

Dr. FELCH. Mr. Chairman and members of the committee.

I am William C. Felch, a physician in the practice of internal medicine in Rye, N.Y. I am the vice chairman of the AMA Council on Legislation.

With me is Harry N. Peterson, director of AMA's Division of Legislative Activity.

AMA is pleased to discuss the President's proposed health budget.

The medicaid program was enacted in 1965 to provide medical services to needy individuals. Since its enactment, that program has experienced steadily rising costs as a result of many factors.

Mr. Chairman, medicaid is only one of the many programs contributing to the record level of Government spending, which is now recognized as a core problem in our country's economic difficulties.

The AMA supports the overall initiatives of the President as he seeks to restore some measure of fiscal stability and integrity to our Government budget policies.

Our association expects that when cuts are made across the board to reduce deficit spending, some reductions in the Federal health spending will also take place. Deductions in health spending should not impair the provisions of necessary services to the Nation's poor.

We are pleased that the President has given assurance that the so-called safety net programs, those designed to protect persons in need will be maintained.

Since the beginning of the medicaid program, the AMA has encouraged coverage of high-quality care for all beneficiaries.

The administration proposes to alter the present system under which States are automatically entitled to open-ended Federal medicaid matching funds by establishing a closed-end system designed

to prevent Federal expenditures from going beyond a certain level regardless of State spending.

The AMA recognized the need for such an action to gain control of the rapid growth in medicaid expenditures. We believe that the overriding concern at this time must be to take steps necessary to improve the Nation's economy.

Unless reversed, economic hard times, factory closings, and increased unemployment would only exacerbate the problem and increase the financial burdens on medicaid.

We endorse the cap concept as a part of the President's program for improving the overall economic situation.

In conjunction with the proposed medicaid cap, the administration has indicated that it will seek legislation to give the States greater flexibility in administering medicaid benefits. This will give the States additional flexibility to target necessary services to the truly needy.

Such flexibility will be essential to the States in their efforts to achieve desired economies to offset the cut in Federal assistance.

It is difficult to predict just how the States will respond should the proposed cap be enacted. We hope the States may be able to effect significant savings in their program so that they can offer a medicaid program under the cap without decreasing the quality of care.

And achieving economies in the medicaid program will not be an easy task. There can be no question, however, that much can be done to help assure that medicaid achieves a greater cost effectiveness while still maintaining the availability of quality care.

States should be able to maintain essential services through greater efficiencies in administration by elimination of fraud and abuse through vigorous enforcement of the law and by judicious cutbacks where eligibility has become overextended.

Some States may have to examine the priorities expressed in their benefit package and shift their priorities to adequate funding of basic and essential services.

Now, we have not had any opportunity to examine any legislative provisions for the administration's medicaid cap proposal, but we can at this time offer a suggestion for consideration in developing such legislation. We are concerned about the ability of many State health departments to handle the additional reponsibilities resulting from these changes.

While the easing of arbitrary Federal requirements will tend to make adminstration somewhat easier, many States may lack the proper health organization and staff to perform in a way that will assure essential preventive and medical delivery services to those who need them.

So, because of these uncertainties, we suggest that a provision be included to monitor the effects of the cap after its enactment.

In addition, Congress might also consider establishing a special medicaid safety valve that might be triggered to assist States which, because of severe local economic problems, suffer major dislocations in their medicaid program as a result of the imposition of Federal limitations.

Moreover, Congress should examine whether the specific increase limit of 5 percent for 1982 and the GNP deflater for future increases are appropriate devices.

As Congress considers the administration's medicaid proposal and as the States implement program changes, we must caution against adoption of the view that medicaid cutbacks can be easily absorbed merely through decreasing the level of reimbursement to providers of medical care.

In most States, drastic limitations in provider reimbursement have already been in place for some years. The State cannot reduce reimbursement levels and expect to maintain the current quality of care under the medicaid program.

Mr. Chairman, we intend to work closely with our State medical societies to monitor future developments. The medicaid program, with all its faults and limitations, must be supported with the necessary resources to furnish adequate services to those in need.

Mr. Chairman, the next couple of pages has to do with maternal and child health. In general, we support the notion of block grants. We would suggest that the committee might wish to consider whether or not two is the right number for block grants. Perhaps, three or more would be an appropriate number.

Maternal and child health programs, which the AMA has always supported and continues to support under the administration's proposal, are divided within the two blocks, with part of those maternal and child health programs going to the basic services block, and part of them going to the preventive services block.

The committee and Congress might wish to consider the possibility to grouping all maternal and child health programs in a single block, or somehow otherwise making sure that more efficient distribution of those services would be achieved.

But we support the general block grant approach as a way of giving the States greater flexibility to determine their own public health priorities and address State needs.

So, in conclusion——

Senator HEINZ. Well, without objection, Dr. Felch, your entire testimony will be part of the record.

Dr. FELCH. Very good. Thank you.

Senator HEINZ. Do you have any concluding comments you would like to make?

Dr. FELCH. The administration's proposals for a medicaid cap and for block grants for categorical maternal and child health programs reflect a significant shift in the relative responsibilities of the Federal and State governments toward health programs.

The proposals represent the view that States are better able to determine the needs of their citizens and to target program funding to better meet local needs.

The proposals also reflect the potential cost savings that can be achieved through an end to rigid, expensive, and complex Federal requirements.

The AMA, in supporting the thrust of the adminstration's proposals intends to encourage State and local medical societies to continue and increase their activity in their States as advocates for maternal and child health programs and for proper medical care of individuals.

Mr. Chairman, I would be please to respond to any questions that the committee may have.

Senator HEINZ. Thank you, Dr. Felch.

Senator Long.

Senator LONG. I have no questions, thank you.

Senator HEINZ. Senator Dole, do you have any questions?

The CHAIRMAN. I have no questions.

Senator HEINZ. Dr. Felch, I have two questions.

You indicated in the paraphrase of your statement that you support the current maternal child health program under title V and that title provides for a good deal of discretion to the States in targeting of that program to meet local needs. In a sense, title V is already a block grant.

Is it your suggestion that the kind of framework in title V be used as the framework for a larger block grant, which would include various categoriical programs for health services for mothers and children and, if so, which of the categorical programs would you include with title V in such a block grant?

Dr. FELCH. Yes, sir, I think we do support the idea of having the title V kind of structure as part of the——

Senator HEINZ. That is to say a block grant——

Dr. FELCH. A block grant.

Senator HEINZ. Aimed at mothers and children?

Dr. FELCH. That is correct.

Senator HEINZ. What other categorical programs would you like to see included in that block grant, if any?

Dr. FELCH. Under the adminstration's proposal, the block relating to preventive services includes the adolescent pregnancy programs, programs to deter smoking and alcohol use, genetic disease programs, family planning services. The maternal and child health grant program of title V, as far as the delivery of services is concerned, and a sudden infant death program are under the direct services grant.

Our suggestion to you is that you might want to consider linking those programs, since they deal with the same population of beneficiaries.

Senator HEINZ. I see

Now, in the Special Committee on Aging, which hearings I chaired last week, we are examining the question of the medicaid cap. Specifically as it will affect senior citizens nonetheless we have addressed some broad questions regarding the medicaid cap that really hit in two areas.

One is: What is likely to be the impact of such a cap, which you touched on in your statement, on medicaid reimbursement rates? If the effect is to further reduce reimbursement rates to physicians, obviously the result would be fewer physicians participating. The indigent would seek different kinds of health care, principally emergency room, hospital-based care, as opposed to services provided in less costly clinic or physican office setting.

It is my understanding that some 30 percent of all physicians do not participate in medicaid.

Second, that there is another 40 percent for whom medicaid patients only represent 10 percent of their entire practice. So, that

means that approximately 30 percent of the physicians in this country treat most of the medicaid patients.

Now, is there any reason to believe that if we impose a medicaid cap, States might increase physican reimbursement rates in order to reap some savings by replacing some care now obtained in emergency rooms with office or clinic base care?

Dr. FELCH. Yes, sir. Some of the use of medicaid services, according to physicians, is a matter of geography, of course. In my particular community, the potential population of medicaid patients is less than 10 percent. So, my practice is made up of about that proportion.

As far as reimbursement is concerned though, I think you are absolutely right. Many physicians choose not to see medicaid patients because the medicaid reimbursement schedule is less than the cost of doing business in their offices, and I would think it would make good sense to suggest that if that amount were increased even modestly that more doctors would be willing to see medicaid patients.

Senator HEINZ. Well, my question is not so much whether it is a good idea or not. My question is: If we impose a medicaid cap, will or will not States increase the medicaid reinbursement rate to physicians? Or are they going to reduce it? How are States going to react, in your judgment, to a medicaid cap on this issue?

Dr. FELCH. I imagine the 50 States will all react differently to it, but I would hope that some of them would see fit to try the experiment of increasing the physician fees to see whether or not the cost—their total cost would not decrease because of lesser emergency room and more ambulatory care.

Senator HEINZ. So, you think that increasing reimbursement rates is a more likely response by the States than further reducing physician reimbursement rates?

Dr. FELCH. I am of an age where I am skeptical that State bureaucrats are likely to leap on anything that smacks of being a little bit venturesome. So, do I think it's likely, the answer is no.

Senator HEINZ. The answer is "no."

Dr. FELCH. Do I think it would be advisable; the answer is "yes."

Senator HEINZ. Well, in the light of the current reimbursement rates, there's an irony. The irony is that although we have a so-called freedom of choice provision under medicaid, indeed, that freedom of choice—because of the relatively low participation of physicians in medicaid—is relatively limited. If we do allow States to contract for services on a bid basis of some kind in order to further reduce costs, it seems to me that this would further limit the number of physicians that would participate under medicaid. Is that a reasonable scenario?

Dr. FELCH. I missed the last part. It would further the number.

Senator HEINZ. It would seem further to restrict—

Dr. FELCH. Oh, to restrict.

Senator HEINZ [continuing]. The number of physicians that would, in fact, be participating in the medicaid?

Dr. FELCH. I would agree with that. I would agree with that. It would restrict it more.

Senator HEINZ. All right. Thank you very much, Doctor.

Dr. FELCH. You are welcome.

Senator HEINZ. I appreciate your being here.
Senator Long, do you have any other questions?
Senator LONG. No, thank you.
[The prepared statement of Dr. William Felch follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION PRESENTED BY WILLIAM C. FELCH, M.D.

SUMMARY STATEMENT

The American Medical Association supports the overall initiatives of the President as he seeks to restore some measure of fiscal stability and integrity to our government budget policies. Where cuts are made across the board to reduce government spending, our Association expects that some reductions in federal health spending will also take place. The AMA supports the Medicaid cap in principle and the block grant concept as part of the President's program for improving the overall economic situation.

We recognize that the proposed cap on federal Medicaid expenditures might result in some decrease in overall Medicaid services in a state if the state does not increase its funding efforts to offset decreases in federal Medicaid payments. We hope that states may be able to effect significant enough savings in their programs to enable them to offer a Medicaid program under the cap without decreasing quality of care.

The AMA strongly supports maternal health programs and the provision of high quality prenatal care for all mothers. The AMA supported the maternal health program under Title V of the Social Security Act as a program that provides states with discretion in targeting resources to meet local needs.

The AMA supports the concept of block grants. However, the Congress should carefully consider the assignment of the programs into the two proposed general blocks and also consider whether more than two block grants should be created. Maternal and child health categorical programs are split between the two proposed blocks. The Congress may wish to consider grouping maternal and child health programs into the same block or, perhaps, into a separate block.

The AMA supports the concept of permitting states limited fund transfers between the block grants.

STATEMENT

Mr. Chairman and Members of the Committee, I am William C. Felch, M.D., a physician in the practice of internal medicine in Rye, New York. I am the Vice-Chairman of the AMA Council on Legislation. With me is Harry N. Peterson, Director of AMA's Division of Legislative Activity.

The American Medical Association is pleased to discuss the President's proposed health budget, particularly the proposals to place a "cap" on federal Medicaid expenditures and to place the maternal and child health program, established under Title V of the Social Security Act, into a proposed health services block grant.

MEDICAID CAP

The Medicaid program was enacted in 1965 to provide medical services to needy individuals. Since its enactment, that program has experienced steadily rising costs. The costs have resulted from many factors—expanded numbers of beneficiaries, increased benefits, and general increases in costs of administration and services. Program costs have been further aggravated by the effects of a depressed economy and double-digit inflation which pervades the entire economy. In 1979 some 22 million persons were eligible for Medicaid, and during the last decade the costs of the program have risen over 400%. Expenditures in 1979 reached approximately $21.7 billion of which some $11.8 billion were federal funds and $9.9 billion state funds.

Mr. Chairman, Medicaid is only one of the many programs contributing to the record level of government spending, which is recognized as a core problem in our country's economic difficulties. The American Medical Association supports the overall initiatives of the President as he seeks to restore some measure of fiscal stability and integrity to our government budget policies. There can be littel question that the American people wish to have the government do whatever it can to stem the rapidly rising cost of living. The nation requires a commitment by government, the private sector and the individual household to do what each can—individually and collectively—to hold down the recent dramatic increases in the cost of living. Where cuts are made across the board to reduce deficit spending, our

Association expects that some reductions in federal health spending will also take place.

We are concerned—as are you, Mr. Chairman and others on the Committee—that the reductions in health spending should not impair the provision of necesary services to the nation's poor. We are pleased the President has given assurance that the so-called "safety net" programs, those designed to protect persons in need, will be maintained. Since the beginning of the Medicaid program, the American Medical Association has encouraged coverage of high quality care of all beneficiaries.

The Administration's Medicaid Proposal.—As the Medicaid program is currently structured, states may enter into agreements with the Secretary of Health and Human Services to finance health care services for public assistance recipients and certain other low income individuals and families. The amount of federal expenditures is in effect controlled by the states. The federal government is obligated to match a state's Medicaid expenditures according to a percentage formula which varies from state to state. This had posed a basic dilemma for the Administration's effort to control federal spending.

The Administration proposes to alter the present system under which states are automatically entitled to open-ended federal Mediciad matching funds by establishing a closed-end system designed to prevent federal expenditures from going beyond a certain level, regardless of state spending. The proposal would impose a ceiling, or "cap," on federal Medicaid expenditures at a level $100 million below the Office of Management and Budget current base estimate for Medicaid outlays in fiscal year 1981. Federal expenditures would be allowed to increase by 5 percent in fiscal year 1982 and, in fiscal years thereafter, the federal ceiling would increase only with the rate of inflation as measured by the GNP deflator. Under the proposal each state would have a ceiling allocation based on its current relative share of total federal Medicaid expenditures.

The AMA recognizes the need for such an action to gain control of the rapid growth in Medicaid expenditures, where the federal costs are tied to independent state actions.

We believe that the overrinding concern at this must be to take steps necessary to improve the nation's economy. Unless reversed, economic hard times, factory closings, and any resulting increased unemployment would only exacerbate the problem and increase the financial burdens on Medicaid. We endorse the cap concept as a part of the President's program for improving the overall economic situation.

This proposal has been described as an interim measure to limit costs pending the enactment of comprehensive legislation designed to resolve health care cost problems. The Administration plans to introduce such legislation later this year, but details of the proposal are not available at this time.

In conjunction with the proposed Medicaid cap, the Administration has indicated that it will seek legislation to give the states greater flexibility in administering Medicaid benefits. According to the March 10 budget message, this will give states additional flexibility to target necessary services to the truly needy. States deem such flexibility essential to their efforts to achieve desired economies to offset the cut in federal assistance.

It is difficult to predict just how the states will respond should the proposed cap be enacted. We recognize that the limit on federal Medicaid expenditures might result in some decrease in overall Medicaid services in a state if it does not increase its funding efforts to offset decreases in federal Medicaid payments. We hope that states may be able to effect significant savings in their programs so they can offer a Medicaid program under the cap without decreasing the quality of care.

Achieving economies in the Medicaid program will not be an easy task. There can be no question, however, that much can be done to help assure that Medicaid achieves greater cost-effectiveness while maintaining the availability of quality care. States should be able to maintain essential services through greater efficiencies in administration, and by elimination of fraud and abuse through vigorous enforcement of the law and judicious cutbacks where eligibility has become over-extended. Some states may have to examine the priorities expressed in their benefit package and place priorities on adequate funding of basis and essential services.

We have not had an opportunity to examine any legislative provisions of the Administration's Medicaid cap proposal, but we can at this time offer a suggestion for consderation in developing such legislation. We are concerned about the ability of many state health departments to handle the additional responsibilities resulting from these changes. While the easing of arbitrary federal requirements will tend to make administration easier, many states may lack the proper health organization and staff to perform in a way that will assure essential preventive and medical delivery services to those who need them. Because of the uncertainties involved in the ability of the states, we suggest that a provision be included to monitor the

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effects of the cap after its enactment. In conjunction with the federal monitoring of the cap effect on the states, Congress might also consider establishing a special Medicaid "safety valve" that might be triggered to assist states which, due to severe local economic problems, suffer extreme dislocation in their Medicaid programs as a result of the imposition of federal limitations Moreover, Congress should examine whether the specific limit of 5 percent for a 1982 increase and the use of the GNP deflator future increases are appropriate as the cap.

As Congress considers the Administration's Medicaid proposal and as the states implement program changes, we must caution against adoption of the view that Medicaid cutbacks can be easily absorbed merely through decreasing the level of reimbursement to providers of medical care. In most states drastic reductions in provider reimbursement have already occurred over recent years. A state cannot reduce reimbursement levels and expect to maintain the current quality of care under the Medicare program.

Mr. Chairman, we intend to work closely with our state medical societies to monitor future developments. The Medicaid program—with all its faults and limitations—must be supported with the necessary resources to furnish adequate services to those in need.

Maternal and child health

The importance of maternal and child health care cannot be over-estimated. Access to high quality prenatal, postnatal and pediatric care has profound impact upon the outcome of pregnancy and the lives of children. Any investment in these new and young lives will inure to the benefit of this and future generations. Our children do represent our future. They deserve a national commitment and effort directed toward their health.

The AMA strongly supports maternal health programs and the provision of high quality prenatal care for all mothers. The AMA has supported the maternal and child health programs under Title V of the Social Security Act and has recommended improvements and modifications in those programs. We have long viewed Title V favorably as a program that provides states discretion in targeting resources to meet local needs.

No discussion of federal programs in the maternal and child health area can take place outside of the general context of the Administration's overall proposal of transferring present categorical health programs into two block grants, one for basic health, mental health and substance abuse services, and the other for preventive health services.

The AMA supports the concepts of block grants. The present system of some 26 separately mandated and funded categorical health programs for grants to states has resulted in excessive federal regimentation of resources. This has resulted, in effect, in a determination of local needs through decisions made in Washington with a concomitant lessening of state responsibilities in the public health area.

We support the consolidation of present programs into block grant programs. We must raise, however, certain concerns with regard to the proposed block grant program.

Two bills have been introduced to establish two block grants in the health area: the basic health services block grant, and the preventive health services block grant. It will be important to examine not only the assignment of the programs into these two general categories, but also whether more than two blocks should be created.

Programs affecting maternal and child health have been split between the two blocks. Thus, one finds the adolescent pregnancy programs, programs to deter smoking and alcohol use among children and adolescents, genetic disease programs, and family planning services included in the preventive health services while the maternal and child health grant program under Title V of the Social Security Act and Sudden Infant Death program are included under the Basic Health Services Block Grant.

We recognize that the block grant concept could be eroded if each health interest seeks its own separate block grant. The end result could be little more than a minor variation from the present categorical grant system. However, for the block grant program to be effective, we believe that there should be a rational connection between the programs that are being subsumed into each of the block grants so that overall parameters for the states can be more clearly delineated.

Accordingly, the Congress may wish to consider a reordering of the programs now assigned to each of the health blocks. Specifically, Congress may wish to consider grouping maternal and child health programs into the same block or, perhaps, into a separate block.

In its discussion of the block grant proposals, the Administration has indicated that additional flexibility would be granted the states by permitting each state to

take up to 10 percent of federal money from one block grant and use it in the other block grant category. While we have not seen this proposal spelled out in legislation, we support the concept of permitting states limited fund transfers between the block grants.

Mr. Chairman, we support the block grant approach as a way of giving the states greater flexibility to determine their own public health priorities and addressing state needs, provided that the state health departments are so structured and organized to effectively administer the programs to assure proper recognition of all public health priorities. Likewise, we believe that major economies will be available because of a major reduction in federal administrative expenses and also in state and provider costs incurred in meeting federal regulatory requirements.

CONCLUSION

The Administration's proposals for a Medicaid cap and for block grants for categorical maternal and child health programs reflect a significant shift in the relative responsibilities of the federal and state governments toward health programs. The proposals represent the view that states are better able to determine the needs of their citizens and to target program funding to better meet local needs. The proposals also reflect the potential cost savings that can be achieved through an end to rigid, expensive and complex federal requirements.

The AMA, in supporting the thrust of the Administration's proposals, intends to encourage state and local medical societies to continue and increase their activity in their states as advocates for maternal and child health programs and for proper medical care of individuals, and to encourage cost savings in those programs without a reduction in quality of services. The AMA, along with state medical societies, will seek the establishment of appropriate priorities for health care.

Mr. Chairman, we will be pleased to respond to any questions the Committee may have.

Senator HEINZ. The next witness is Mr. Charles V. Womer.

Mr. Womer, you may proceed.

STATEMENT OF CHARLES B. WOMER, PRESIDENT, UNIVERSITY OF CLEVELAND, CLEVELAND, OHIO, ON BEHALF OF THE AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY DR. JAMES BENTLEY, ASSISTANT DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, D.C.

Mr. WOMER. Mr. Chairman and Senator Long, I am Charles Womer, immediate past chairman of the Association of American Medical Colleges and a former chairman of the Association's Council of Teaching Hospitals. I am accompanied this morning by James Bentley, associate director of the AAMC Department of Teaching Hospitals.

We are pleased to have this opportunity to testify on the impact of the administration's proposed medicaid reductions on the Nation's teaching hospitals

Teaching hospitals both publicly and privately owned are major sources of the care provided to medicare recipients.

This reflects the innercity location of many teaching hospitals and the intensive tertiary care services they provide.

University Hospitals of Cleveland, of which I am president, is an independent hospital affiliated with Case-Western Reserve University and is located on Cleveland's near eastside.

In 1979, the hospital cared for 32,000 inpatients and had 51,000 emergency room visits and 163,000 outpatient visits.

Medicaid recipients were 15 percent of our inpatients and approximately 35 percent of our outpatient and emergency visits.

In addition, the hospital provided over $7 million of uncompensated charity care to patients unable to pay for the care they

required. This heavy involvement in medicaid services in the additional charity care is characteristic of many teaching hospitals.

In 1977, 25 percent or more of the patients admitted to the 65 members of the Council of Teaching Hospitals were medicaid recipients.

Recently it has been estimated that charity and uncompensated care provided by 270 major teaching hospitals currently amounts to approximately $2 billion a year.

I cite these statistics to emphasize four points to our written testimony.

One, medicaid expenditures underwrite the costs of medical care, including hospital services provided our needy citizens. Their medical needs and the resulting costs incurred by hospitals will remain even if the Federal Government reduces medicaid funding.

Two, because of the geographic location and health service needs of medicaid recipients, their hospital services are disproportionately concentrated in a relatively small number of major teaching hospitals.

Three, hospitals providing substantial amounts of medicaid services are already incurring significant additional amounts of charity and uncompensated care to patients not meeting the categorical requirements of medicaid.

And, four, medicaid spending reductions which further limit eligibility, reduce the scope of services for hospital payments will increase the financial instability and distress of major urban teaching hospitals in areas which already are impacted by high unemployment.

In the hope of reducing some of the impact of its proposal, the administration has promised, but not specified, increased administrative flexibility for the medicaid program. It has been suggested that the administration might increase program flexibility by being more lenient in its approval of medicaid waivers allowing States to reduce payments.

If this committee is asked to consider expanding the Secretary's waiver authority, the AAMC strongly urges the committee to insure, one, that due process and appeal provisions are included for both providers and recipients, and, two, that the Secretary must monitor and regularly report upon the impact of altered State policies on recipients' access to care.

Another program change that some are advocating is amending the law to give the Secretary authority to permit States to mandate on a least-cost basis a recipient's physician and hospital.

Teaching hospitals, because of their multiple missions, incur higher average costs than community hospitals.

As described in the written statement, the AAMC strongly opposes a denial-of-choice provision for medicaid; however, if this committee seriously considers such a change, we strongly urge you to add legislative language insuring that the denial-of-choice amendment will not adversely effect recipient's access to hospitals having graduate medical education programs and tertiary care services.

Secretary Schweiker and others proposed health care financing changes to promote provider competition. This long-term policy

interest in competition is inconsistent with and will be undermined by reduced medicaid expenditures.

Medicaid cutbacks in eligibility and/or benefits will increase hospital bad debts and charity care. Hospitals with significant uncompensated care will be severely handicapped in their ability to compete with hospitals serving primarily paying patients.

If this administration wishes to pursue a more competitive health care service system, then it is essential that it not cripple its own long-term objective with a short-run program of medicaid cuts.

The AAMC strongly urges this committee to reject the proposed medicaid budget reductions, and the Congress to look at other areas of the proposed Federal budget where reductions would not have the devastating impacts which cutbacks in the medicaid program will have.

Thank you for permitting me to testify before you. I would be happy to respond to any questions you may have.

Senator HEINZ. Senator Long.

Senator LONG. I have no questions, Mr. Chairman.

Senator HEINZ. I have one question.

You mentioned that you wanted to see due process incorporated into any expanded waiver authority for the Secretary of HHS; is that correct?

Mr. WOMER. Yes.

Senator HEINZ. Now, there are two methods of exercising that due process. One is at the Federal level where you can have a period of public comment, and so forth.

The other is to mandate that, when waivers are taken advantage of at the State level, that there be a good deal of State-oriented due process. Which is it that you are advocating?

Mr. WOMER. I think I would urge that at least the beginning steps be at the State level, but I do think that there has to be a final step at the Federal level. In other words, the State——

Senator HEINZ. You want both?

Mr. WOMER [continuing]. No. I'm taking steps just such as going from the district court to the court of appeals.

It does seem to me that as a last resort, the Federal Government has to be there to keep the States honest. If the State appeal—if the final step in the appeal is at the State level, it is questionable to me that in some instances, there would be really objective due process.

So, I think I'd say it is much like as the Federal health planning legislation now in which the appeals are at the State level, but there is a final recourse to the Federal level. And as I have no information on it, but it is my general understanding that that has been rarely used.

Senator HEINZ. Mr. Womer, thank you very much. We appreciate your testimony.

Mr. WOMER. Thank you.

[The prepared statement of Mr. Charles Womer follows:]

STATEMENT ON THE ADMINISTRATION'S MEDICAID BUDGET REDUCTIONS, MADE BY CHARLES B. WOMER ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman and Members of the Committee, I am Charles Womer, immediate past chairman of the Association of American Medical Colleges and a former

Chairman of the Association's Council of Teaching Hospitals. I am accompanied this morning by James Bentley, Associate Director of the AAMC's Department of Teaching Hospitals. We are pleased to have this opportunity to testify on the impact of the Administration's proposed Medicaid reductions on the nation's teaching hospitals. Teaching hospitals, both publicly and privately owned, are major sources of the care provided to Medicaid recipients. This reflects the inner-city location of many teaching hospitals and the intensive tertiary care services they provide.

University Hospitals of Cleveland, of which I am President, is a independent hospital affiliated by mutual agreement with Case-Western Reserve University. Located on Cleveland's near eastside, the hospital has 982 beds. In 1979, the hospital care for 32,000 admissions, 51,000 emergency room visits, and 163,000 outpatient visits. Medicaid recipients were 15 percent of our inpatients and approximately 35 percent of our outpatient and emergency visits. In addition, the hospital provided over $7 million of charity and uncompensated care to patients unable to pay for the care they required. This heavy involvement in Medicaid services and the additional charity care is characteristic of many teaching hospitals. In 1977, 65 hospitals belonging to the Council of Teaching Hospitals had at least 25 percent of their admissions who were Medicaid recipients. Recently, it has been estimated that charity and uncompensated care provided at 270 major teaching hospitals currently amounts to approximately $2 billion a year.

I cite these statistics to emphasize four points in our written testimony:

1. Medicaid expenditures underwrite *the costs* of medical care, including hospital services provided our needy citizens. Their medical needs and the resulting costs incurred by hospitals will remain even if the federal government reduces Medicaid funding.

2. Because of the geographic location and health service needs of Medicaid recipients, their hospital services are disproportionately concentrated in a relatively small number of major teaching hospitals.

3. Hospitals providing substantial amounts of Medicaid services are already incurring significant additional amounts of charity and uncompensated care to patients not meeting the categorical requirements of Medicaid. And,

4. Given the concentration of Medicaid recipients and their continuing needs for hospital care, Medicaid spending reductions which further limit elgibility, reduce the scope of services, or cut hospital payments will increase the financial instability and distress of major urban teaching hospitals.

In the hope of reducing some of the advance impact of its proposal, the Administration has promised, but not specified, increased administrative flexibility for the Medicaid program. State governors and Medicaid program directors have supported this ill-defined flexibility. The AAMC is seriously concerned about a reduction in program requirements. Medicaid physician fee schedules are already significantly below Medicare levels. A recent AAMC study shows Medicaid fees for four common services are frequently less than 50 percent of the allowable Medicare payment. Further reducing them threatens the limited physician acceptance of patients. For hospitals, medicaid program policy requires states to follow Medicare's cost reimbursement rules. Significant variations from this policy require a program waiver from the Secretary. It has been suggested that the Administration might increase program flexibility by being more lenient in its approval of Medicaid waivers. If this Committee is asked to consider expanding the Secretary's waiver authority, the AAMC strongly urges the Committee to ensure (1) that due process and appeal provisions are included for both providers and recipients and (2) that the Secretary must monitor and regularly report upon the impact of altered state policies on recipients' access to care.

Another program change that some are advocating is amending the law to give the Secretary authority to permit states to mandate, on a least cost basis, a recipient's physician and hospital. Teaching hospitals—because of their multiple missions including medical and allied health manpower education, the introduction of new patient care services, and the provision of tertiary care services—incur higher average costs than community hospitals whose mission is only primary and secondary patient care. As described in the written statement, the AAMC strongly opposes a denial-of-choice provision for Medicaid; however, if this Committee seriously considers such a change, we strongly urge you to add legislative language ensuring that the denial-of-choice amendment will not adversely effect recipient's access to hospitals having graduate medical education programs.

When Secretary Schweiker testified before your Committee on March 17th, he stated that Administration would be proposing health care financing changes which promote provider competition. This long-term policy interest in competition is inconsistent with and will be undermined by reduced Medicaid expenditures. Medicaid cutbacks in eligibility and/or benefits will increase hospital bad debts and charity

care. Hospitals with significant uncompensated care will be severely handicapped in their ability to compete with ho· itals serving primarily paying patients. If this Administration wishes to pursue a more competitive health service system, than it is essential that it not cripple its own long-term objective with a short-run program of Medicaid cuts.

The Administration's proposal will have several adverse hospital outcomes: increased hospital bad debts and charity requirements, increased hospital financial distress, increased hospital prices for charge-paying patients, a reversal of hospital accomplishments in providing a one-class standard of care, and a serious barrier to the Administration's interest in competition. Therefore, the AAMC strongly urges this Committee to reject the proposed Medicaid budget reductions, and the Congress to look to other areas of the proposed federal budget where reductions would not have the devastating impacts which cutbacks in the Medicaid program will have.

Thank you for permitting me to testify before you on this important Administration proposal. I would be happy to answer any questions you have.

SUMMARY OF WRITTEN TESTIMONY ON THE ADMINISTRATION'S MEDICAID BUDGET PROPOSAL

1. The Administration's proposal does not challenge the Medicaid program's accomplishments in improving the health status and service utilization gains of the needy.
2. The Administration has asked Congress to make decisions about Medicaid financing policy now and health service policy decisions later. The AAMC believes health service decisions should precede program expenditure decisions. The AAMC further believes that the Administration's program to get our nation moving again must invest the funds necessary to maintain the health of its population, including its needy citizens.
3. The Administration's proposed Medicaid cutbacks are dramatic reductions—an 18.8 percent reduction by fiscal year 1986.
4. It is unlikely that the states will increase their Medicaid expenditure to offset the reduced federal Medicaid expenditures. Therefore, reduced federal funding will lead to significant cuts in Medicaid benefits and/or exclusion of larger numbers of the poor from the program.
5. Because the medical service needs of the poor will remain despite Medicaid cutbacks, hospital costs for charity and uncompensated care will increase. Increases will b· significantly concentrated in the nation's teaching hospitals.
6. Medicaid reductions which increase the demand for charity care will increase the financial instability and distress of major urban teaching hospitals.
7. The AAMC believes the non-economic costs of a denial-of-choice policy for Medicaid greatly outweigh the allegedly higher economic costs of maintaining a recipients's freedom to select his/her physician and hospital.
8. Because the Administration's proposed Medicaid budget reductions are likely to increase economically segregated charity care and to undermine the financial stability of urban teaching hospitals, the AAMC strongly urges:

The Committee to reject the proposed Medicaid budget reductions; and

The Congress to look to other areas of the proposed federal budget where reductions would not have the devastating impacts which cutbacks in the Medicaid program will have.

TESTIMONY SUBMITTED ON THE ADMINISTRATION'S MEDICAID BUDGET REDUCTION PROPOSAL

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the Administration's Medicaid Reduction Proposal. In addition to representing all of the nation's medical schools and 71 academic societies, the Association's Council of Teaching Hospitals (COTH) includes 328 state, municipal, and not-for-profit hospitals. These hospitals account for 18 percent of the admissions and 32 percent of the outpatient visits provided by all non-federal, short-term hospitals. Many of these hospitals are located in the inner-cities of our nation's urban areas and provide health care services to large Medicaid populations residing in their local neighborhoods. Others, regardless of their location, provide intensive tertiary care services to significant numbers of Medicaid patients. In fiscal year 1977, a survey of the COTH membership identified 65 major teaching hospitals whose admission included at least 25 percent Medicaid patients. As a result of teaching hospital care of Medicaid patients, the Adminstration's proposal to limit federal funding for the Medicaid program is of vital concern to the Association and its members.

In 1965, our nation committed itself to a program providing mainstream, high quality, up-to-date medical services for its poorer citizens. Under Title XIX, millions of needy Americans have acquired financial assistance for their medical care costs. While the Medicaid program has had implementation and operational problems, it is accomplishing many of its objectives.

The Administration's budget documents and Secretary Schweiker's March 17th testimony before this Committee do not challenge the medicaid program's accomplishments. Significantly, both documents ignore the health status and service utilization gains which Medicaid has helped our poorer citizens achieve. Thus, the Administration is not asking for a reduction in the program's budget because of its ineffectiveness. Rather, the Administration is looking at the program solely in terms of its expenditures. This financial focus is clearly demonstrated by the availability of documents detailing proposed Medicaid spending reductions and the absence of documents specifying either how such reductions would be distributed to the states or what added program flexibility would be granted the states. Put simply, the Administration is asking the Congress to make medical and social welfare decisions on an expenditure basis, rather than on the basis of program accomplishment or social policy. You have been asked to make decisions about dollars now and currently unknown program policies later.

The Association supports President Reagan's objectives to get our nation moving again, to increase its productive capacity and employment, and to expand our national wealth. The Association disagrees, however, with an implementing stategy which implies we can get America going without maintaining and enhancing the health of its needy citizens. To have a more productive nation which emphasizes the initiative of its citizens, the United States must invest the funds necessary to protect its most crucial asset—the health of its population. Providing the needy with the services to restore and maintain their health enables them to contribute to our national revitalization. As a result, the AAMC has a fundamental philosophical disagreement with this proposal of the Administration. The AAMC believes that health service decisions should precede, not follow, program expenditure decisions.

The Administration proposes (1) a $100 million expenditure reduction in the fiscal year which is already half over, (2) a five percent increase to cover both additional Medicaid recipients and price increases in fiscal year 1982, and (3) an expenditure cap limited by the increase in the Gross National Product deflator in subsequent years. In presenting this proposal, the Administration has not asked for a sunset provision for the proposed cap. If accepted and enacted, the cap would run indefinitely.

The magnitude of the proposed cap should not be ignored. In his February 18th address to a joint session of Congress, President Reagan specified in dollar terms, for fiscal years 1981-1986, the impact of the proposed cap. Translated into percentage reductions, these figures become the dramatic cutbacks presented in Table 1. By 1986, the projected cap would reduce projected federal Medicaid funding by 18.8 percent. From a somewhat different perspective, if total Medicaid spending increased throgh fiscal year 1986 as projected by the Administration, the federal share of total program expenditures would decline from 54.28 percent in fiscal year 1979 to 44.08 percent in fiscal year 1986, as shown in Table 2. This dramatic reduction in federal support suggests that the health care "safety net" for the poor will be loosely woven at best.

TABLE 1.—PERCENTAGE REDUCTION IN FEDERAL MEDICAID OUTLAYS PROPOSED BY THE ADMINISTRATION ON FEB. 18, 1981

	Outlays (in millions)		
	Current base [1]	Policy reduction [1]	Percentage change
1981	16,480	−100	−0.6
1982	18,213	−1,013	−5.6
1983	20,441	−1,986	−9.7
1984	22,529	−2,930	−13.0
1985	24,593	−3,916	−15.9
1986	26,732	−5,021	−18.8

[1] Source: Feb 18, 1981, "America's New Beginning: A Program for Economic Recovery."

TABLE 2.—ESTIMATING STATE AND LOCAL EXPENDITURES RESULTING FROM THE PROPOSED REDUCTION IN FEDERAL EXPENDITURES

	Current Federal base	Fiscal year 1979 Federal share (percent)	Estimated total program outlays	Proposed Federal outlays	Percentage of Federal funding
1981	16,480	54.28	$30,361	$16,380	53.95
1982	18,213	54.28	33,554	17,200	51.26
1983	20,441	54.28	37,658	18,455	49.00
1984	22,529	54.28	41,505	19,599	47.22
1985	24,593	54.28	45,308	20,667	45.61
1986	26,732	54.28	49,248	21,711	44.08

Note: Assumptions—1 1979 Federal share of medicaid expenditures (54 28 percent0 would apply through fiscal year 1986; 2 States would maintain projected medicaid expenditures by replacing reduced Federal expenditures with State and local funds.

Despite its accomplishments, the Medicaid program is not a comprehensive, consistently available program. Aside from the mandatory benefits, services provided by the states vary substantially. The number and mix of eligible beneficiaries also varies. It does not cover all of the poor. In 1979, the Department of Health and Human Services estimated that more than 10 million individuals with incomes below 55 percent of the official poverty standard were not covered by Medicaid. And, those who are covered often have significant benefit limitations. Despite the exclusion of many genuinely poor and the limited coverage provided to those included, the Administration proposes to reduce federal Medicaid expenditures.

It would be reassuring if the states would be able tc make up for the proposed reduction in federal expenditures, but this is unlikely:

The limited coverage currently available testifies to the inability or unwillingness of some states to provide increased Medicaid support,

Some states, especially those in the Northeast and Great Lakes regions, have experienced a severe economic recession in the past two years which has reduced expected tax receipts and increased governmental expenditures,

Some states have experienced sharp increases in unemployment which are increasing the number eligible for Medicaid, and

Some states and local areas have already stretched their taxing authorities to the limit.

While the Administration has promised, but not specifically proposed, increased state program flexibility in the hope of reducing the adverse impact of reduced federal funding, the flexibility is already severely constrained by past actions and present circumstances.

States providing only the minimum of services to a small percentage of the poor will be faced with further reductions of services and/or limiting program eligibility.

States which have undertaken significant cost containment programs have already squeezed out any "fat" in the system.

Medicaid recipients are geographically concentrated in urban areas where many hosptials currently are in financial difficulty and could face bankruyptcy if payments are reduced.

Medicaid physician fee schedules are already significantly below Medicare levels. Further reducing them threatens the limited physician acceptance of patients. For example, a recent AAMC study shows Medicaid fees for four common services (comprehensive hospital visit, dilation and curettage, gastrointestinal x-ray series, and right inguinal hernia) are frequently less than 50 percent of the allowable Medicare payment.

Medicaid program policy requires states to follow Medicare's cost reimbursement rules for hospitals unless a specific alternative has been approved by the HHS Secretary. This has helped provide Medicaid recipients with access to hospitals. If states respond to reduced federal funding with cutbacks on hospital payments, many hospitals will have to reconsider acceptance of Medicaid patients.

Given these circumstances, reduced federal funding undoubtedly will result in significant cuts in Medicaid benefits, exclusion from the program of larger numbers of the poor, and increasing difficulties in obtaining access to necessary and covered services.

Reducing the number of Medicaid recipients or their covered services will not decrease hospital operating costs. Illness and injury are not limited to well-insured and financially independent patients. Our poor citizens have significant and justifiable needs for medical services. They will continue to present themselves to hospitals for this care. While some hospitals may be unable or unwilling to meet these needs, teaching hospitals have a long tradition of caring for patients who are unable

to pay for their care. But, this tradition is limited by the hospital's ultimate need to obtain sufficient revenues to meet operating expenses.

At the present time, it has been estimated that major teaching hospitals provide at least $2.0 billion in charity and uncompensated care.[1] This charity care increases the average costs to all other paying patients by an estimated $34.03 per adjusted patient day[2] and $18.29 per clinic visit.[3] Reductions in the services provided and the people assisted by the Medicaid program will increase charity and uncompensated care for many of the nation's major teaching hospitals. Because of their locations, surrounding neighborhoods, and readily accessible ambulatory care services, many teaching hospitals are major providers of services to patients covered by Medicaid. Medicaid cutbacks undoubtedly would also increase the number of patients who are (1) transferred to teaching hospitals when their benefits are exhausted, (2) referred to the teaching hospital because their care is expected to be more expensive than the allowed Medicaid payment, or (3) sent to the teaching hospitals ambulatory clinics because of their accessibility. Governmentally sponsored hospitals and specialty hospitals (e.g., childrens, cancer, and rehabilitiation) are particularly susceptible to this patient "dumping". Thus, a proposal to decrease Medicaid funding and services promises to increase already significant charity and uncompensated care.

Medicaid payment for hospital services generally pays the "reasonable costs" of caring for program benficiaries. Medicaid payments *do not* help underwrite bad debts and charity care. Reductions in Medicaid funding, however, will increase bad debts and charity care, and hospitals will either have to charge paying patients still higher prices or the hospital's financial stability will be undermined. A number of hospitals have already reached or exceeded the practical limit in their ability to increase their charges to cover indigent care losses and are experiencing strong resistence to their high charges from HMOs, commercial insurers, and business and industry.

The Congress should not assume that other revenues are available to underwrite the costs that would remain if Medicaid funding were reduced. The Medicare program is not allowed to assist hospitals with the costs of their charity care. And the networks of municipal hospitals that once provided a major share of charity care have been reduced in capacity and are often chronically underfunded. Medicaid reductions undoubtedly will increase the financial instability and distress of major urban teaching hospitals.

One proposal that could reduce Medicaid recipients' use of teaching hospitals is amending the law to give the Secretary of HHS authority to permit states to mandate, on a least-cost basis, a recipient's physician and hospital. The AAMC opposed such a denial-of-choice in the last Congress and would vigorously oppose such a proposal again this year. The expectation of some who advocate this proposal is that Medicaid patients currently cared for in relatively high-cost teaching hospitals would be cared for in less costly hospitals. The AAMC seriously questions whether adopting this proposal will decrease either Medicaid program costs or total societal costs To date, many of the less expensive hospitals have not attempted to attract Medicaid patients. In fact, some hospitals adopt strategies to avoid them. Many of these hospitals are already operating at high occupancy and in locations unaccessible to Medicaid patients. Moreover, if those lower cost hospitals do accept increasing numbers of Medicaid patients, those hospitals will have to duplicate the extensive medical, nursing, patient education, and social services costs which urban teaching hospitals have found necessary to care for Medicaid patients. Finally, while a denial-of-choice provision might remove some of the more routine Medicaid patients from teaching hospitals, the intensely ill patients requiring tertiary care services will remain. With only these sicker Medicaid patients remaining, average costs per Medicaid patient in tertiary care teaching hospitals will increase.

In addition to its questionable economic impact, a denial-of-choice provision threatens to institutionalize a two-class system of medical services by separating hospitals into those for public, charity patients and those for private, paying patients. Simultaneously, it communicates a dangerous perception to students in training which could seriously impair our national efforts to obtain a more even geographic and specialty mix of physicians and other health professionals. As a result, the Association believes that the non-economic costs of a denial-of-choice policy greatly outweigh the allegedly higher economic costs of maintaining recipient's freedom to select his physician and hospital.

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[1] John W. Colloton, "An Analysis of Proposed Competitive Health System Plans and the Implications for Teaching Hospitals," presented at the Sixth Private Sector Conference, Duke University Medical Center, March 23, 1981, Page 25.

[2] *Ibid*, Exhibit I-5.

[3] *Ibid*, Exhibit I-3.

Hospitals traditionally have attempted to meet the medical needs of their patients. Since 1965, hospitals serving the poor have made major gains in implementing a one class standard of care. With funds available from Medicaid and Medicare, charity wards have been dismantled, and many charity clinics have been terminated. Increasingly, patients are seen, cared for, and treated without regard to their ability to pay. Substantial reductions in the Medicaid program will reverse these accomplishments. As uncompensated care increases, charity clinics, charity wards, and charity hospitals are likely to return. The poor and near poor will again be offered econmically segregated medical care. This would be a dramatic change in social and public policy.

Given this adverse outcome, the AAMC strongly urges this Committee to reject the Admistration's Medicaid cutbacks. The Association urges the Committee to remove this issue from the budget process. The Association urges the Congress to look instead to other areas of the proposed federal budget where reductions would not have the potentially devastating impacts which cutbacks in the Medicaid program will have. If the Committee wishes to modify significantly the Medicaid program, the AAMC urges the Committee to introduce a complete proposal as a major legislative bill, to hold full hearings with opportunity for Medicaid providers and recipients to testify, and to act only after the implications of the proposal are full known and considered.

Senator HEINZ. Our next panel of witnesses will consist of Dr. David Fedson, Dr. Jack Gamble, and Mr. James Kerrigan.

I am going to ask Mr. Gamble to be our first witness. Senator Long particularly wanted to hear your testimony. I gather he has some questions and I am going to accord Senator Long the opportunity to question you, Dr. Gamble, before the other witnesses have had a chance to give their statements.

I thank the other witnesses for their willingness for us to go a little out of sequence.

STATEMENTS OF: DAVID FEDSON, M.D., ASSOCIATE PROFESSOR OF MEDICINE, UNIVERSITY OF CHICAGO, CHICAGO, ILL., ON BEHALF OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE, ACCOMPANIED BY DENNIS BARBER, DIRECTOR OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE; JACK W. GAMBLE, M.D., MEMBER, AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS, ACCOMPANIED BY EDWIN S. COHEN, PARTNER, COVINGTON & BURLING, WASHINGTON, D.C.; JAMES P. KERRIGAN, COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION, WASHINGTON, D.C., ACCOMPANIED BY ROY BRETTER, SECRETARY, COUNCIL OF LEGISLATION OF THE AMERICAN DENTAL ASSOCIATION

Dr. GAMBLE. Good morning.

My name is Jack Gamble, I am an oral and maxillofacial surgeon practicing in Shreveport, La., and the past president of the American Association of Oral and Maxillofacial Surgeons, on whose behalf I appear today.

Accompanying me is Edwin S. Cohen, of Covington and Burling, counsel to the association.

The association is the official organization for the dental specialty of oral and maxillofacial surgery and represents approximately 3,800 oral surgeons.

Following extensive consideration during three Congresses, the 1980 Reconciliation Act corrected two important inequities affecting the patients of oral surgeons in the reimbursement provisions under medicare.

The administration has proposed repeal of these provisions as part of its program for budget austerity.

The administration has not questioned the merits of these provisions and they were not considered controversial by Congress.

The first of these two corrections of inequities that were made in the 1980 law was to permit a patient to be reimbursed for a covered service when he is treated by an oral surgeon if he would be reimbursed for the service if he had been treated by a physician.

For example, when a patient needs diagnostic care or treatment of oral infections prior to the 1980 amendment, the patient was reimbursed only if the services were performed by a physician and not if performed by an oral surgeon. There was no warrant for this untenable distinction in the statute.

The 1980 amendment did not extend the coverage of medicare; it merely provided that the patient would not be denied reimbursement for a covered treatment solely because he was treated by an oral surgeon who specializes in these services.

The second inequity for medicare patients, which was corrected by the 1980 amendment concerns reimbursement for hospitalization required by the severity of the patient's dental procedure.

Prior to the 1980 amendment, the medicare statute, as interpreted by the Social Security Administration, reimbursed inpatient hospital expenses in the case of a noncovered dental procedure such as multiple or complex extractions and other complex surgery only if hospitalization was required on account of a preexisting medical condition, such as a patient with a history of repeated heart attacks.

I can sit here before you and tell you that I have had patients that have been denied reimbursement that have exactly that type of problem. And the Senator from Louisiana has those cases in his office.

The effect was to preclude hospitalization coverage if, in the judgment of the patient's dentist, the severity of the dental procedure, taking into account the patient's age and general physical condition, requires hospitalization for its safe performance.

As the 1980 amendment provided, medicare should permit the dentist responsible for the patient's care to exercise his professional judgment as to when the risk from the procedure and the patients' circumstances requires hospitalization.

We urge the committee to retain these 1980 amendments and not to restore the unfortunate and inequitable distinctions of the prior law.

Gentlemen, I appreciate the privilege of appearing before you and would be happy to answer any questions.

Senator HEINZ. Senator Long.

Senator LONG. Thank you, Mr. Chairman.

If I recall correctly, we were talking about a situation where the law was completely arbitrary.

If work was done by a dental surgeon, he was not permitted reimbursement. This might be work that must be done in a hospital, but the dental surgeon was not permitted to be reimbursed. However, if the same service were performed by a physician, he was permitted reimbursement. That is completely arbitrary. There is no logic to it except that it just happens that way.

When we put the law together, we just weren't sufficiently informed to look at all aspects of the problem and, therefore, we

provided something very discriminatory. We straightened that out in the reconciliation bill last year where we were trying to save money overall.

We did make a big overall saving. We would have saved more than a billion dollars more if the House had gone along with our amendments. But in reducing Federal spending, we thought it only fair to take care of a discrimination that existed.

Now, it is being proposed that the discrimination start all over again just on the basis that it would save money. Your view, as I understand it, is that this would not be right, that this would not be fair, and that it would be completely discriminatory both to the patient and the dental surgeons involved. We shouldn't reenact what amounted to an injustice, and it is really an outrage, just to save some money.

Have I stated your position?

Dr. GAMBLE. That is the basis of our position and we would even go further to state that there are actual cases—as you are well aware, because we have discussed them before—there are cases in our elderly population that require surgery that cannot be done outside of the hospital setting. These people must be hospitalized and they are penalized, if you will, because they are healthy and because they are not utilizing medicare funds. They are denied hospitalization. The oral surgeon is not reimbursed and we are not here asking to be reimbursed. We are asking that these patients have their hospital bills reimbursed when it is absolutely necessary that they be hospitalized.

We are asking that if I treat an oral infection—and I am supposed to be a specialist at treating oral infection—that the patient be reimbursed, if I treat them, the same as if a physician treats that infection.

We feel we have some suggestions how to overcome some of this budget austerity and not repeal these laws. These good laws that have been passed by the 1980 reconciliation bills should not be repealed and we feel, as the Senator from Louisiana suggested earlier, there are some people able to pay a certain amount for their medical care.

We are not all things to all people. We know this is a fact because of our programs in Louisiana. We feel that there's a possibility of upping the deductible on medicare. We feel that it can be budgeted for, and these people can afford it and can do quite well. This would be a tremendous savings.

We feel that there are means tests that could be used, such as need. Some things have to be put on a need basis. Some things have to be put on a can-you-afford-basis, and a tremendous savings could be made.

Don't repeal good laws and then come back 5, 6, 7 years and put them back in. Keep the good laws in and make arrangements to save money in other ways.

Thank you very much.

Senator HEINZ. Thank you, Dr. Gamble.

Dr. FEDSON. Mr. Chairman, members of the committee, I am Dr. David Fedson, associate professor in the Department of Medicine at the University of Chicago.

I am pleased to be here today on behalf of the American College of Preventive Medicine. Accompanying me is Mr. Dennis Barbour, the college's director of prevention policy.

Last year Congress took a major step forward when it passed Public Law 96-611 authorizing medicare to pay for pneumococcal vaccine and its administration.

We urge that this law not be repealed. Pneumonia is the fifth leading cause of death in the United States and the sixth most common cause for hospitalization among the elderly. A substantial portion of all pneumonias are caused by pneumococcal bacteria and over 97 percent of the cost of treating pneumococcal pneumonia in the elderly is spent on hospital care.

It costs $3,300 to treat an elderly person with pneumococcal pneumonia in the hospital. The cost of immunizing a person with pneumococcal vaccine is $13.

With Public Law 96-611, the Congress extended to the elderly the ongoing Federal support it has provided to immunization programs for children since 1962. If this law is in jeopardy, we must ask why should the support which is extended to children in the prevention of major infectious diseases be denied to the elderly.

Now, one argument might be that the vaccine has not been shown to be effective in the elderly, and while it is true that most of the clinical studies of the vaccine have been conducted in younger individuals, at least three studies have suggested that it is effective in older persons.

More important is our knowledge that 90 percent of the elderly will show a good antibody response following vaccination and, on average, this response is well above the threshold necessary for protection.

Antibody response is a scientifically accepted criterion for determining the efficacy of vaccine. Some critics have argued that we still need a randomized controlled clinical trial proving the efficacy among the elderly before embarking on a major immunization program.

Let me point out to the committee that such a study would be extremely difficult and costly to conduct and, more important, would pose serious ethical dilemmas for the invistigators. Half the subjects in such a study would be exposed to the risk of serious pneumococcal infection, which in the elderly may carry a mortality of 25 to 30 percent despite the best of antibiotic therapy.

A second argument would suggest that if the vaccine is of value, the elderly should be willing to pay for it, and a few persons, if they know enough about it, might do so. But I think it unfortunate that a high level of awareness among the elderly about the value of pneumococcal vaccine is unlikely to develop over the next few years.

Given this, perhaps physicians should be counted on to persuade their patients to be immunized, but the sad fact is that informed physicians consistently fail to immunize their patients.

The third argument questions whether or not medicare reimbursement would be cost effective. Now, this problem has been the subject of an extraordinarily extended study by the congressional Office of Technology Assessment and by the Congressional Budget Office.

As this committee knows, the net cost to the medicare program for pneumococcal immunization in the first 3 years would be $43 million, $22 million, and $18 million respectively.

But in the fourth and fifth years, this pattern would be reversed, resulting in net savings of $6 million and $11 million. Over this 5-year period, 5,500 lives would be saved. This program would not only improve the health and well-being of elderly Americans, it will also, within a few years, permanently improve the financial health and well-being of the medicare program itself.

Pneumococcal vaccine is not one of the costly halfway technologies which characterize so much of medical care today. It is one of the very few genuinely decisive and, therefore, inexpensive technologies of modern medicine.

Its effectiveness will solely depend upon the intelligence with which it is used. Congress will choose to either continue to pay for the treatment of this disease or to prevent it.

We urge the committee and the Congress to retain the medicare pneumococcal vaccine program.

Thank you. I would be happy to answer any questions.

Senator HEINZ. Dr. Fedson, thank you.

Dr. Kerrigan.

Dr. KERRIGAN. Mr. Chairman and Senator Long, I'm Dr. James P. Kerrigan of Washington, D.C. I am a member of the Council on Legislation of the American Dental Association, which I am representing today.

Accompanying me is Mr. Roy Bredder, secretary of that council.

We are pleased to have the opportunity to outline the concerns of the association with the potential impact of two of the budget proposals offered by the administration.

With respect to the proposed repeal of the dental amendments only recently included in Public Law 96-499, we are submitting a statement for the record and we fully endorse the position stated by Dr. Gamble on behalf of the American Association of Oral and Maxillofacial Surgeons.

Those amendments to correct basic inequities in the medicare program were adopted after several years of consideration by Congress. Their cost is inconsequential and should be retained.

Our second concern is with the potential consequences of placing a cap on Federal contributions to the medicaid program. The association has longstanding policy favoring the inclusion of dental care benefits for all person eligible under medicaid. The policy stems from the association's belief that dental care is an integral part of total health care and that indigent persons should have equal access with the rest of the population in needed dental care services.

While we have not yet had the opportunity to see the actual legislation which will be introduced on behalf of the administration, we are concerned over the effects that an abrupt shift of medicaid financial responsibility may have. If experience can be used as a guide, the States might be expected to reduce or eliminate the adult dental programs that now exist.

Many of these programs, even now, are inadequate and very often only render emergency services, and these are the only ones that many States provide.

Medicaid's early and periodic screening, diagnosis, and treatment program requires that dental benefits be provided to children of medicaid-eligible families. This mandate is important in attempting to assure these children receive the dental care necessary to form the basis of good oral health.

We assume this mandate for children will continue. We believe that this same mandate should also apply for all medicaid-eligible individuals.

We also view, with concern, recent reports that the administration is willing to adopt a policy which would limit individual freedom of choice of providers under the medicaid program. We think that the elimination of the freedom of choice concept can result in a second level of health care for the individuals who are eligible.

Freedom of choice is basic to the health care delivery system. An individual should be able to receive his health care services where he desires.

We understand that the status of the economy makes difficult decisions necessary and support the overall objectives of the President's financial program. However, our commitment is to insure the availability of proper dental care for medicaid-eligible individuals.

We believe that it is important, and we would like to point out to you the effect which this proposal could have on the dental health care of 7 million needy individuals who are on medicaid benefits.

I would be pleased to try to answer any questions you may have, Mr. Chairman.

Senator HEINZ. Thank you very much, Dr. Kerrigan.

I don't have any questions for you.

I think your testimony has helped us very much.

Dr. KERRIGAN. Thank you for your time.

[The prepared statements of the preceding panel follow:]

SUMMARY OF STATEMENT OF JACK GAMBLE ON BEHALF OF THE AMFRICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

1. The 1980 Reconciliation Act corrects, effective July 1, 1981, two important inequities affecting the patients of oral surgeons. These amendments—

(i) permit an oral surgeon's patient to obtain reimbursement under Part B if the same services would be covered if they were provided by a physician, and

(ii) provide reimbursement under Part A for inpatient hospital stays that are required because of the severity of the patient's dental procedure.

2. The Administration has proposed repeal of these provisions as part of its program for budget austerity and has estimated the aggregate savings for the two provisions to be $2 million for fiscal 1981 and $17 million for fiscal 1982 when they are fully effective. The Administration has not questioned the merits of these provisions.

3. These two inequities were corrected following careful consideration during three Congresses. They were not considered controversial and the amendment to Part B was passed in the Senate during the 95th Congress as well as being enacted together with the amendment to Part A by the 96th Congress.

4. To restore these inequities is unfair to Medicare patients and detrimental to their health. The corrections carefully made in 1980 should not be repealed in 1981.

STATEMENT OF JACK GAMBLE

My name is Jack Gamble. I am an oral and maxillofacial surgeon practicing in Shreveport, Louisiana and the Past President of the American Association of Oral and Maxillofacial Surgeons ("AAOMS"). I am accompanied by Edwin S. Cohen, a member of the law firm of Covington & Burling, the Association's counsel.

AAOMS is the official organization for the dental specialty of oral and maxillofacial surgery. AAOMS represents approximately 3,800 oral surgeons from all fifty states, the District of Columbia and Puerto. Today all members must complete three or more years in an accredited surgical residency in a hospital following completion of four years of dental school. Members practice oral and maxillofacial surgery in offices and in hospitals as medical staff members.

Following extensive consideration during three Congresses, the 1980 Reconciliation Act corrected two important inequities affecting the patients of oral surgeons in the reimbursement provisions under Medicare. The changes are not effective until July 1, 1981. One correction permits an oral surgeon's patient to obtain reimbursement under Part B if the same services would be covered if they were provided by a physician. The other correction provides reimbursement under Part A for inpatient hospital stays that are required because of the severity of the patient's dental procedure.

The Administration has proposed repeal of these provisions as part of its program for budget austerity. The Administration's cost estimate for these provisions is $2 million for fiscal 1981 and $17 million for fiscal 1982 when they are fully effective.

The Administration has not questioned the merits of these provisions, and they were not considered controversial by Congress. Indeed, the amendment to Part B was passed in the Senate during the 95th Congress as well as being enacted together with the amendment to Part A by the 96th Congress.

To restore these inequities is unfair to Medicare patients and detrimental to their health. AAOMS urges that the corrections which were carefully enacted in 1980 not be repealed in 1981.

The professional practice of oral surgeons overlaps with that of physicians to a significant extent. Both perform surgery and reduce fractures related to the jaw. Both also perform nonsurgical functions, including, for example, diagnostic care and treatment of oral infections. All of these services are covered if the provider is a physician. However, under the law as now in effect, only surgical services are covered if an oral surgeon is the provider. The 1980 amendment would correct this discrepancy, effective in July 1981. The amendment does not change the present exclusion under Medicare of regular dental services.

To reinstate a discrimination based solely upon the academic degree of the provider has serious consequences for the patient, and is important to the professional life of the oral surgeon. If the patient is aware of the discrimination, his freedom of choice of provider between a physician and an oral surgeon is prejudiced. If he is not aware of this legal pitfall when he is treated by an oral surgeon, he will be deprived of reimbursement for what surely must appear to him to be a completely arbitrary distinction.

I want to emphasize that the 1980 amendment, which the Administration proposes to repeal, does not add coverage for any services not presently covered in the case of physicians. The Administration's cost estimate treats correction of the discrimination in the overlapping area of practice together with the 1980 amendment for inpatient stays for dental patients, and it is not possible to ascertain how much, if any, of the proposed savings is allocable to the overlap amendment. The actual cash outlay which may be saved by repeal of the overlap amendment will likely be small and is not an appropriate target for an austerity program. Its repeal would not curtail or eliminate a benefit; it would only perpetuate a discrepancy in a patient's access to the services which remain covered.

The second inequity for Medicare patients which was corrected by the 1980 amendments concerns reimbursement for hospitalization required by the severity of a patient's dental procedure. This correction does increase benefits and thereby the cost of the program.

Prior to the effective date of the 1980 amendment, coverage under Part A of inpatient hospital expenses in connection with services provided by a dentist depends largely upon whether or not the dental service itself is covered under Part B. If the dental procedure is covered under Part B, the inpatient hospital expenses are also covered under Part A. Most dental procedures are not under Part B, however, pursuant to the general exclusion for dental services. The present Medicare statute as interpreted by the Social Security Administration severely restricts the payment of inpatient hospital expenses in the case of dental procedures which are not covered under Part B. Coverage of the hospital expenses is permitted only if performance of the dental procedure risks aggravation of a specific, pre-existing medical impairment to the extent that hospitalization would be required for proper management, control or treatment of that pre-existing medical impairment. The only example of a medical impairment justifying the hospitalization of a patient for a noncovered dental service given in the Social Security Administration's "Intermediary Manual" is "a patient who has a history of repeated heart attacks who must

have all of his teeth extracted." No weight is given to the severity of the dental procedure alone or in conjunction with the patient's age and general health.

The effect of existing law has been to preclude hospitalization coverage where, in the judgment of the patient's dentist, the severity of the dental procedure alone requires hospitalization for its safe performance. Professional opinion establishes that many relatively healthy, aged individuals should have available the sophistication and immediacy of a hospital, inpatient level of care when undergoing extensive or serious dental procedures. In these cases, however, the patient must find his own means of payment for the hospital expenses.

AAOMS strongly disagrees with the Administration's characterization of inpatient care in these circumstances as a low-priority benefit expansion. Permitting the 1980 amendment to become effective will not increase the coverage of dental fees. It will only permit the dentist responsible for the patient's care to exercise his professional judgment as to when the risk from the procedure in the patient's circumstances requires hospitalization.

STATEMENT BY DAVID S. FEDSON, M.D., FACP

Mr. Chairman, members of the Committee, I am Dr. David Fedson, Associate Professor in the Department of Medicine at the University of Chicago. I am pleased to be here today on behalf of the American College of Preventive Medicine. Accompanying me is Dennis J. Barbour, the College's Director of Prevention Policy.

We are here today to discuss some of the important scientific and policy considerations which led to Congressional passage of Public Law 96-611 authorizing the Medicare program to reimburse the costs of pneumococcal vaccine and its administration. We urge that this important preventive health care measure not be repealed. Retention of Public Law 96-611 is also strongly supported by the American Association of Retired Persons, American Lung Association, Association of Schools of Public Health, Association of State and Territorial Health Officials, Association of Teachers of Preventive Medicine, Consumer Coalition for Health, National Council of Senior Citizens and the National Retired Teachers Association.

The American College of Preventive Medicine is one of 22 recognized medical specialty societies composed of over 2,000 physicians. Its members are teachers, researchers, administrators, and practitioners in preventive medicine, a specialty which has four sub-areas of board certification: general preventive medicine, public health, occupational medicine, and aerospace medicine. Now in its 28th year, the College was founded to provide a forum for the advancement and dissemination of knowledge in the field.

Two of the College's highest priorities are our prevention policy and education programs. The prevention policy program is responsible for formulating broad national policies for improving the nation's health and the advancement of prevention as a science, while the education program provides support for undergraduate, graduate, and continuing education for prevention practitioners.

In his essay on the technology of medicine written ten years ago, Lewis Thomas provided the context within which the issue before this committee should be considered [1]. I would like to paraphrase his remarks.

Thomas said that when we measure the cost and effectiveness of what is done in the management of disease we must recognize that there are three quite different levels of technology in medicine. First there is the large body of what might be termed "nontechnology." This is the supportive care which tides patients through diseases that by and large are not understood. It is indispensible, but its cost is very high and getting higher all the time.

At the next level is something best termed "halfway technology." This represents the things that are done after the fact; it makes up for disease or postpones death. Chronic dialysis and organ transplants are examples of halfway technology. This level of technology is, at the same time, highly sophisticated and profoundly primitive. It costs an enormous amount of money.

The third type of technology is the kind that is so effective that it often attracts little public notice. Yet this is the genuinely decisive technology of modern medicine, and it is exemplified best by modern methods of immunization. The point to be made about this kind of technology is that it comes as a result of a genuine understanding of disease mechanisms. When it becomes available it is inexpensive and easy to deliver. When medicine possesses the outright capacity to prevent human disease, the cost of the technology itself is never a major problem. The price is never as high as the cost of managing the same disease during the earlier stages of nontechnology or halfway technology.

Last year, Congress took a major step forward when it passed Public Law 96-611 authorizing Medicare to pay for pneumococcal vaccine and its administration. This

benefit is scheduled to take effect on July 1st. Pneumococcal vaccine promises to have its greatest effect in the prevention of pneumococcal pneumonia among the elderly.

It is important to recognize that pneumonia remains the fifth leading cause of death in the United States. In 1977 pneumonia caused the deaths of almost 39,000 elderly persons [2]. In addition, it was the sixth most common cause for hospitalization among the aged, accounting for 2.2 million days of hospital care. The Medicare program has in the past and will continue to pay for much of the medical care costs due to pneumonia. Projected outlays in 1981 are expected to exceed $600 million.

A substantial portion of all pneumonias are caused by pneumococcal bacteria. Persons above the age of 65 are particularly susceptible. Death rates are 2.5 times higher for persons aged 65 to 74 and 10 times higher for those over 75 compared to rates for the population as a whole. Over 97 percent of the cost of treating pneumococcal pneumonia in the elderly is spent on hospital care. The average episode of hospital care for an elderly person costs $3300 and can be expected to increase substantially, because inpatient hospital care is one of the most rapidly rising costs in the Medicare program. The total cost of immunizing a person with pneumococcal vaccine is $11.50.

The principle that pneumococcal infections could be prevented was discovered almost 100 years ago. Crude vaccines were tested in the early part of this century. Stimulated by the need to prevent pneumococcal pneumonia in the military, an effective vaccine was developed during World War II [3], only to fall by the wayside with the introduction of penicillin, an effective treatment for most pneumococcal infections. Penicillin, however, did not eliminate the problem of pneumococcal pneumonia. Dr. Robert Austrian's pioneering studies demonstrated that many persons died of the disease despite penicillin therapy [4]. More recently the disturbing discovery has been made that certain strains of pneumococcal bacteria have become resistant to penicillin and other antimicrobial agents [5].

These observations led to a renewed effort to develop an effective vaccine, a $12 million effort supported in part by Federally funded programs of the NIH. These studies determined that a vaccine containing 14 of the 83 serotypes of pneumococci would cover 75 to 80 percent of the organisms responsible for serious pneumococcal infections [6]. Before the vaccine was released on the market, clinical and epidemiologic studies involving more than 40,000 persons both here and abroad demonstrated its immunogenicity, safety and efficacy [7]. Overall, the vaccine was shown to reduce the incidence of pneumococcal pneumonia due to serotypes in the vaccine by approximately 80 percent. Immunity following vaccination lasts at least five years and probably much longer.

Before pneumococcal vaccine was licensed for general use, these clinical and epidemiologic studies were extensively reviewed by the Bureau of Biologics and the Advisory Committee on Immunization Practices of the Public Health Service. The vaccine was recommended for use among individuals who are at high risk of developing serious of fatal pneumococcal infections [8]. All persons over the age of 65 are included in this high risk population.

In passing Public Law 96-611 Congress extended to the elderly the ongoing Federal support it has provided to immunization programs for children since 1962. The importance of this support is best illustrated in the control of measles. A decade of experience has shown that when Federal funds were made available to immunization programs the incidence of measles fell dramatically. When support was cut back or eliminated, the number of cases increased [9]. The history of measles control strongly suggests that Federal financing may be necessary to effectively control certain infectious diseases. Such support may be even more important for the two preventable infectious diseases of adults—pneumococcal pneumonia and influenza. In general the combined mortality from these two diseases exceeds that due to all of the immunizable diseases of childhood by a factor of approximately 200 [10]. Three-fourths of this mortality occurs among the Medicare population.

The serious question which must be asked here today is this—should the elderly be denied the Federal support which is extended to children in the prevention of the major infectious diseases which threaten their well-being and their very lives? And if so, on what basis can withholding such support be justified? At least three arguments might be advanced to defend the position that Federal support is unwarranted.

The first argument says that although pneumococcal vaccine has been shown to be protective, the convincing studies have been conducted in generally healthy young adults, and there are no data proving vaccine efficacy among the elderly. It is true that most of the subjects in the clinical trials of pneumococcal vaccine have been younger adults, but a study dating back to the 1940's suggested that vaccine would be effective in preventing pneumococcal pneumonia in the elderly [11]. More

recent clinical trials among older persons in North Carolina and in the Kaiser Health Plan in San Francisco have produced results consistent with the level of efficacy shown in studies in younger individuals.

Just as important are indirect studies which indicate that immunization of the elderly with pneumococcal vaccine should be highly effective. It is clear that among the elderly, 90 percent will show a good antibody response to the vaccine and that on average this response is well above the threshold necessary for protection [12, 14]. Antibody response is a scientifically accepted criterion for determining the efficacy of vaccines and is the standard generally used by the Bureau of Biologics. Only a few persons who receive pneumococcal vaccine fail to develop an adequate antibody response and it is in these patients that pneumococcal infections have been observed despite previous immunization [12]. Most of these patients have serious underlying medical conditions which preclude an adequate response to the vaccine [13]. It is important to remember, however, that such patients constitute only a very small fraction of the high risk population for whom the vaccine is recommended. Although a carefully controlled randomized clinical trial might settle once and for all the question of vaccine efficacy among the elderly, such a study would be extremely difficult and costly to conduct, an perhaps more important, would pose serious ethical dilemmas for investigators. Such a study would force investigators to withhold from half the study subjects a demonstrably safe vaccine and expose them to the risk of serious pneumococcal infection which in the elderly may be accompanied by a mortality rate of 25 to 30 percent despite antibiotic treatment.

When pneumococcal vaccine was licensed, it was the consensus view among experts both within and outside the Government that available information on the efficacy of the vaccine in various high risk groups was adequate [15]. Since then no evidence has appeared that would challenge the view that pneumococcal vaccination of the elderly should be effective. This view was reaffirmed by a group of experts convened by the Bureau of Biologics three months ago.

The second argument would accept the vaccine's efficacy and say that, given its demonstrated value, the elderly should be willing to pay for it themselves. Certainly among the very well informed, one might find many who would gladly pay to be immunized. However, we have no information on the extent to which the elderly recognize their susceptibility to pneumococcal infection, its seriousness should they become ill and the safety and efficacy of the vaccine. Based upon my personal experience as a practicing general internist, I believe that it would be most unwise if we were to anticipate a high level of awareness developing on this matter over the next few years. We know that despite more than a decade of repeated Federal recommendations on the value of influenza vaccine, a survey among the elderly in 1973 revealed that approximately half had no appreciation for the severity of the illness or the value of the immunication, and four out of five were unaware that the Federal government recommended they be immunized [16]. Given this, however, it might be argued that knowledgeable physicians should be able to persuade their patients to accept and pay for pneumococcal vaccine. Again we have little information of physicians' perceptions regarding the value of pneumococcal immunization, but I can say with a confidence based upon my own studies regarding influenza vaccine that for the most part well-informed physicians will consistently fail to effectively translate their knowledge into clinical practice [12]. Since few individuals may be expected to come forth on their own and ask for pneumococcal vaccine, we must continue to rely upon physicians and other health providers to actively offer vaccine to their patients. In the three years since pneumococcal vaccine became available only five million doses have been distributed. If we are to improve upon this record and successfully immunize the elderly, we may require the kind of incentive that would be provided by Medicare reimbursement.

The third argument, or perhaps it is better termed a question, is the one which in all likelihood is uppermost in the minds of the members of Congress, and that is the issue of whether or not Medicare reimbursement for pneumococcal immunization will be cost effective. This problem has been the subject of an extraordinarily detailed study by the Congressional Office of Technology Assessment [7, 18]. Under base case assumptions, it was found that the net cost to Medicare would come to $5 per person, and with a vaccination rate of 21.5 percent net discounted expenses would total $26 million. The analysis was quite sensitive to changes in the variables used. Using less conservative assumptions (which many would regard as more realistic) the amalysis predicted savings of $5 per person and $14 million for the Medicare program as a whole.

A second study which speaks to this question is the recent analysis of the direct and indirect costs and benefits of pneumococcal immunization among high risk persons enrolled in a health maintenance organization in Utah [19]. In this study, the benefit-cost ratio was determined to be 2.32, suggesting that a program which

immunized all persons over the age of 50, as well as younger persons with chronic high risk conditions, could be justified on a cost-benefit basis. Although the use of more conservative assumptions in this analysis might reveal that the costs of immunizaton would outweigh the benefits [20], in all likelihood the benefits of immunizing persons over the age of 65 years would still exceed the costs.

A third study which suports Medicare reimbursement for pneumococcal immunization has been prepared by the Congressional Budget Office [2]. In the main case, the costs of vaccination would initially exceed savings in medical care costs for pneumococcal peneumonia. First, second and third year net costs are projected to be $43 million, $22 million and $18 million, respectively. But after only three years, the pattern is reversed and savings exceed costs. Fourth and fifth year net savings to Medicare are projected at $6 million and $11 million, respectively. Over a five year period, an estimated 5,550 lives would be saved. In this analysis the number of lives saved and the net costs to Medicare would vary depending upon vaccination rates and limits on the maximum allowable charge that would be reimbursed. But one fact is strikingly evident from this study: regardless of which assumptions are used, after three or at most four years an ongoing program of support for pneumococcal immunization would each year result in a net reduction in Medicare outlays for the treatment of pneumococcal pneumonia. One can only conclude that an investment in this program will not only improve the physical health and well-being of elderly Americans, it will also within a few years permanently improve the financial health and well-being of the Medicare program itself.

Soon after pneumococcal vaccine became available, the failure to immunize more than small numbers of high risk individuals suggested that immunization was at a crossroads [21]. Today we remain at that crossroads. In pneumococcal vaccine we have in hand one of the genuinely decisive technologies of modern medicine. It effectiveness will depend soley upon the intelligence with which it is used. This is an issue which the Congress cannot avoid, for whether or not the vaccine is used, the problem of pneumococcal pneumonia among the elderly will continue to draw upon Federal funds. Pnumococcal vaccine is safe and will undoubtedly be lifesaving. The case for Medicare reimbursement of pneumococcal immunization is compelling and the need is great. Congress has the rare opportunity both to save lives and money. We urge this Committee to reaffirm its wise decision and not repeal this humane and fiscally responsible program.

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Statement of the American Dental Association on the Dental Consequences of the Administration's Spending Reduction Proposals

Mr. Chairman and Members of the Committee, I am Dr. James P. Kerrigan of Washington, D.C. I am a member of the Council on Legislation of the American Dental Association which I am representing today.

We are pleased to have the opportunity to outline the concerns of the Association with the potential impact of two of the budget proposals offered by the Administration.

With respect to the proposed repeal of the dental amendments recently included in Public Law 96-499, we are attaching a separate statement and endorse the position stated by the American Association of Oral and Maxillofacial Surgeons. Those amendments to correct basic inequities in the Medicare program were adopted after several years of consideration by Congress. Their cost is inconsequential and they should be retained.

Our second concern is with the potential consequences of placing a cap on federal contributions to the Medicaid program. The Association has long-standing policy favoring "the inclusion of dental care benefits for all persons eligible under Medicaid". The policy stems from the Association's belief that dental care is an integral part of total health care and that indigent persons should have equal access with the rest of the population to needed dental care services.

While we have not yet had the opportunity to see the actual legislation which will be introduced on behalf of the Administration, we are concerned over the effect that an abrupt shift of Medicaid financial responsibility might have. If experience can be used as a guide, the states might be expected to reduce or eliminate the adult dental programs that now exist. Many of these programs even now are inadequate.

Medicaid's early and periodic screening, diagnosis and treatment program requires that dental benefits be provided to children of Medicaid eligible families. This mandate is important in attempting to assure that these children receive the dental care necessary to help form a basis of good oral health. We believe this same mandate should apply for all Medicaid eligible individuals.

We also view with concern recent reports that the Administration is willing to adopt a policy which would limit individual freedom of choice of provider under the Medicaid program. We think the elimination of the freedom of choice concept can result in a second level of health care for individuals who are eligible for Medicaid. Freedom of choice is basic to the health care delivery system. An individual should be able to receive his health care services where he desires.

We understood that the status of the economy makes difficult decisions necessary. Our commitment is to assuring the availability of proper dental care for Medicaid eligible individuals. We believe it is important that we point out to you the effects which this proposal could have on the dental health of the more than 7 million needy adults who are eligible for Medicaid benefits.

I would be pleased to try to answer any questions you or the other members of the Committee may have.

Statement of the American Dental Association on the Proposal To Repeal Provisions of Public Law 96-499

The Association appreciates the opportunity to present its views to the Committee, but in all candor we regret that it is necessary to comment on a proposal to repeal certain amendments to the Medicare law that have been extensively consid-

ered and acted upon by the Finance Committee and Senate on several prior occasions.

Briefly stated, the amendments that have been targeted for repeal were designed simply to eliminate some long-standing inequities by clarifying the law so that an aged beneficiary would not be denied a benefit (1) where a dentist, acting within the scope of his license and training, performed a service that would be reimbursed if performed by a physician or (2) where hospital expenses necessitated by the severity of a dental condition are incurred.

We thought that when the above amendments were included in Public Law 96-499 just a few months ago the problem had finally been laid to rest. Instead, with the ink barely dry on that law, we are confronted with a recommendation that the amendments be repealed (and the inequities continued) because they are of "low priority".

We respectfully submit, Mr. Chairman, that while the continuation of the inequities may be considered by some to be of low priority because of the small number of Medicare beneficiaries who would be affected, they are of high priority to those few elderly persons who find that reimbursement for a covered service has been denied because a dentist rather than a physician performed the service. Likewise, it is a matter of high priority to those elderly persons who find out after the fact that hospital expenses necessitated by the severity of a dental condition do not qualify for reimbursement.

These are the inequities that last year's amendments were designed to remedy. It could be argued, which we have done on numerous occasions, that the amendments would not have been necessary had the Medicare administrators made a reasonable interpretation of prior law. We have not found any evidence that it ever was the intent of Congress to deny a covered benefit simply because the site of a severe condition is in the oral, maxillofacial region and an aged beneficiary elects to have treatment given by a duly licensed and qualified dentist who has full hospital privileges and the same accountability as his physician colleagues. The same is true of the limited and circumscribed instances where the serverity of a dental procedure itself, when combined with the overall condition of a particular patient requires hospitalization for the safe performance of the procedure and the proper management and control of the patient.

Mr. Chairman, we hope you would agree that the amendments cannot realistically be viewed as providing for "expanded Medicare coverage" when their whole intent and purpose is to give clear direction to the administrators and at the same time eliminate a discriminatory and arbitrary denial of benefits at minimal, if any, additional cost to the government.

In this latter connection, we challenge the cost estimates that have been given to this Committee by the Department of Health and Human Services. We emphatically do not agree that an amendment recognizing the right of a dental practitioner to provide already covered services can have a noticeable impact on Medicare expenditures. Nor do we agree that legitimate hospital expenses for severe oral conditions should be set apart.

To put this aspect of the matter in further perspective we would point out that the exclusionary language in Section 1862(a)(12) of the law remains so broad that the amendments we are discussing cannot reasonably be considered as significantly expanding benefits or increasing costs.

Mr. Chairman, the American Dental Association is sympathetic with many of the efforts that are being made to contain federal expenditures but we do not believe the correction of the inequities we have described can properly be placed in this category. In the interest of fairness and administrative clarity, we strongly urge that the Committee stand behind its recent action and reject the recommendation to repeal the amendments.

Senator HEINZ. Our next witnesses are Mr. David Crowley and Dr. Thomas Bell.

Mr. Crowley, would you please proceed.

STATEMENTS OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING, WASHINGTON, D.C.; THOMAS G. BELL, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, D.C.

Mr. CROWLEY. Senator Heinz, good morning.

Mr name is David Crowley. I am the executive vice president of the American Association of Homes for the Aging.

Senator HEINZ. Might I say that the two of you look very familiar. [Laughter.]

If I had known that I would be presiding over a duplicate hearing, I don't know that I would necessarily have volunteered for it, but knowing how good you both are as witnesses, I'm delighted.

Dr. BELL. Well, Senator, if consistency is any virtue, I want you to know that we are going to be very virtuous.

Senator HEINZ. Without objection your entire statement will be made a part of the record. [Laughter.]

Mr. CROWLEY. I will add brevity, Senator Heinz, since we basically are saying the same thing today that we said Friday before your Senate Committee on Aging. I would just like to add as I mentioned to your staff director, and I'm quite sincere in saying it, that our hearing last week was one of the most probing and beneficial, I think, that I have participated in since I have been in Washington.

I appreciate your taking the lead as chairman of that committee in your role here this morning to give us the opportunity again to make a few points about the proposed medicaid cuts.

I would merely say, Senator, you know, our association represents nonprofit homes providing a range of services to approximately a quarter of a million older people.

We have prepared for you, and for the committee an extensive testimony that delineates some 25 different proposed cost savings that I would like, with your permission, to submit for the record.

I would like just to make a few comments from that testimony this morning.

In terms of the approach we took, we were very cautious and took a very detailed look at the interaction between medicare and medicaid, and our remarks are guided by three key principles.

No. 1, that public assistance should be provided to individuals who are in the greatest need and that need has both a functional and an income definition.

No. 2, that medicaid, in fact, constitutes a catastrophic health program for older Americans. It is an integral component of the social safety net protecting the general welfare of the elderly.

Third, that major systemic changes in the structure of the medicare and medicaid programs should not be made in the haste of the budgetary debate.

Cost savings should be extracted from incremental program changes. Major program reforms should be deferred until a complete analysis can be completed and considerations can be given to the implementation strategy.

Let me make it very clear for the record, Senator, if I might, again, that our position of our association is one of opposition to the cap on medicaid and one of opposition to the idea of block grants for long-term care.

We do believe that savings can best be secured in the short run from incremental changes in the medicare and the medicaid program.

Changes only in medicaid will have the greatest impact on those most in need and might lead to an exploitation of medicare to assume responsibilities beyond its program resources.

The best protection for older Americans comes from a balanced approach which makes incremental changes in both medicare and in medicaid.

In fact, we would argue that given the catastrophic protection afforded to older persons through the interaction of medicare and medicaid that program reductions in medicare will have the least devastating effect.

Senator, as I mentioned before, we have 25 separate cost-saving suggestions, some of which deal with program implementation and some of them deal with provider reimbursement. They are delineated in our testimony. Our major point is that we are concerned about the lowest income people, the increasing number of elderly who are dependent on the medicaid system for the purchase of long-term care.

We are concerned about the whole system of long-term care in this country and the detrimental effect that will occur should the cap be placed on medicaid or should medicaid be, in long-term care, subject to block grants.

So, our testimony delineates our concern for that and the interactive analysis that we see between the two major health programs.

I will be happy to answer any questions that you might have.

Senator HEINZ. Mr. Crowley, thank you.

Dr. Bell.

Dr. BELL. Mr. Chairman, I respectfully request that my written remarks be accepted for the record.

Senator HEINZ. Without objection.

Dr. BELL. I will summarize the key points of my testimony.

The American Health Care Association endorses the following amendments in the medicaid program which would reduce expenditures without damaging delivery of basic services.

First, provide the States with authority to develop cost-effective reimbursement policies for all providers similar to the recent changes in nursing home reimbursement adopted in Public Law 96-499.

Second, permit States to achieve greater program savings in purchase of health care services and medical equipment by amending the present law. For example, amend the freedom of choice provision.

Third, encourage the States to reasonably restrict medically needed eligibility by withholding Federal payments for higher income recipients.

Fourth, amend Federal laws to permit States to develop innovative cost-savings programs, such as copayments and family supplementation.

The American Health Care Association endorses the following initiatives to achieve efficiency in medicaid long-term care services: First, redesign federally mandated survey and certification procedures for maximum efficiency.

Second, revise regulations and eliminate those that are not cost effective or do not relate to patient care.

Third, simply utilization review.

Fourth, develop programs to place patients in the least costly setting that meets their health care needs.

The American Health Care Association opposes the proposal to give States flexibility to achieve program savings through waivers, which are arbitrary and bureaucratic.

The American Health Care Association recommends that the Congress enact statutory changes to allow States to realize reduction of expenditures.

The American Health Care Association supports the National Governors Association's initiative to obtain some of the savings earmarked for medicaid by implementing perspective reimbursement policies in medicare.

We strongly oppose the National Governors Association's proposal to cap only long-term care in title XIX.

Thank you.

Senator HEINZ. Dr. Bell, thank you.

There is a question that I would like to submit to you for your response in writing and it will be made a part of the record.

[The information was subsequently submitted to the committee:]

QUESTIONS ASKED BY SENATOR HEINZ AND DR. BELL'S ANSWERS

Questions. Dr. Bell, in Attachment A to your statement you indicated that many nursing home operators have dropped out of Medicare because of excessive administrative and other requirements.

As you may recall, the 1972 Social Security Amendments provided for a simplified Medicare reimbursement procedure in order to avoid these problems. Under the procedure the Medicare program can simply pay up to 10 percent over and above the State Medicaid rate for purposes of Medicare reimbursement.

If this provision were properly implemented, would skilled nursing facilities be more receptive to accepting Medicare patients?

Answer. The American Health Care Association maintains that many nursing home providers have dropped out of the Medicare program or chosen not to participate because of two key factors: an inappropriate reimbursement formula and excessive administrative requirements.

The current retrospective reimbursement formula used by Medicare is inflationary and contains neither incentives for efficiency nor incentives for participation. AHCA proposes that the best approach to remedy the situation is for Congress to enact Medicare legislation to implement a prospective reimbursement system for skilled nursing facilities (SNF), which includes incentives for efficiency and cost containment. This approach would encourage SNF participation and could result in savings to the program of at least $300 million annually through (a) a reduction in the provision of unnecessary and expensive hospital services to patients awaiting an available nursing home bed, and (b) a reduction in the growth of nursing home costs. Additionally, beneficiaries will be able to recieve the appropriate services in the least costly setting.

The lack of participation by long term care facilities in the Medicare program is widely acknowledged. The effect of the severe shortage of available Medicare long term care beds is that beneficiaries are not able to receive the services they require and the program is incurring expenditures of around $200 per day for these beneficiaries while they are "backed up" in hospitals. Numerous studies and reports indicate that patients are forced to remain in hospitals simply because nursing home beds are not available. This costs the program billions of dollars annually because the rate of a hospital day is typically over four times larger than the rate of a day in a long term care facility. If Medicare certified SNF beds were available, the program would significantly reduce expenditures.

The National Governors' Association has recently addressed this issue and recommended that Medicare's retrospective reasonable cost reimbursement for hospitals should be replaced by prospective reimbursement that encourages efficiency and does not subsidize waste. The NGA appropriately noted that Medicare's "full cost retrospective reimbursement policies are inflationary, and contribute significantly to medical care inflation."

AHCA believes that the implementation of a prospective reimbursement system would lead to increases in the participation of skilled nursing homes in Medicare, reductions in program expenditures, cost containment, and the provision of services in the least costly setting. AHCA therefore has recommended that the statute be

amended to provide for a Medicare reimbursement system for SNFs which includes prospective reimbursement rates, incentives for efficiency, opportunities for profit, and fair recognition of property costs.

The alternative you have raised—implementation of section 249(b) of Public Law 92-603 (1972 amendments to the Social Security Act), i.e. reimbursing Medicare services on the basis of the Medicaid rate—might also encourage more skilled nursing facilities to participate in Medicare because they would be spared the cumbersome cost reporting requirements currently required of participating SNFs. This inducement, however, could be offset by federal and state efforts to reduce Medicaid payment rates, which in turn would reduce Medicare rates under this payment methodology.

Section 249(b) gave HHS the discretion to reimburse participating SNFs on the basis of the State Medicaid rate. Essentially, rather than computing a Medicare rate for facilities based on thier costs as reflected in the Medicare cost report, the rate paid to a provider would be established based on the Medicaid rate adjusted upward by a percentage factor (not to exceed 10 percent to account for different requirements between Medicare and Medicaid. The intent of the provision was to simplify the Medicare reimbursement mechanism.

The amendment provided that HHS would be responsible for promulgating regulations in order to implement the provision. It also provided that the Secretary of HHS would have the authority to elect whether to use the Medicaid rates of the normal Medicare reimbursement formula. Although the law was enacted in 1972, the Secretary has never issued proposed regulation of final regulations to implement this provision.

AHCA believes that Congress must ultimately consider fundamental reform of Medicare reimbursement for long term care services. We would support implementation of 249(b), as an interim measure, if the statute were amended to provide each participating SNF the option of being reimbursed for services to Medicare beneficiaries based on either (a) the Medicaid rate (as appropriately increased to account for Medicare services and requirements not included in the calculation of the rate) or (b) the normal Medicare reimbursement formula. This recommendation, in effect, would shift the option of utilizing the simplified reimbursement alternative—Medicaid rates as a basis for Medicare reimbursement—from HHS to each individual skilled nursing facility. In addition, AHCA recommends that HHS be instructed to issue regulations implementing this provision within 120 days of enactment. It is our view that if the objectives sought (i.e. increased SNF participation in Medicare) are ever to be realized, the authority for exercising the reimbursement options contained in the provision must be removed from HHS and shifted to the provider.

AHCA has engaged the services of a consulting firm to examine the effect of the enactment of prospective reimbursement for skilled nursing services on Title XVIII, particularly on overall program costs and participation of providers. When the study is completed, we will forward it to you and other members of the Senate Finance Committee for your review.

Dr. Bell. Thank you very much, Mr. Chairman, we will be glad to do so.

Senator Heinz. Dr. Bell, Mr. Crowley, thank you very much. You were not asked to answer any questions today, but you were last week and you were superb.

Mr. Crowley. Thank you, Senator.

I'll rest on that one.

Senator Heinz. Thank you.

[The prepared statements of the preceding panel follow:]

Written Testimony of the American Health Care Association

The American Health Care Association (AHCA), which represents 7,500 nursing homes nationwide, supports the efforts of the Administration and the Congress to restore the viability of the American economy by reducing the growth of the Federal budget. Our members, their employees and the residents that they serve, have felt the sting of inflation. We are committed to working with the Administration and the Congress to find a cure for this economic disease.

Nursing home providers, however, like the members of the Senate Finance Committee, also have a duty to assess the impact of budget cutting on the elderly and handicapped—our mutual constituents. The President has proposed to reduce Medicaid funding by $1 billion in fiscal year 1982 and to cap Federal Medicaid expenditures in future years. Nearly 50 percent of the residents of nursing homes are

supported by the Medicaid program nationwide. Sustained budget reductions of the magnitude proposed by the Administration may have a harmful impact on the availability and quality of long term care services for the poor, unless they are carried out in a responsible and equitable manner.

AHCA believes that any reduction of Medicaid funding should adhere to the following basic principles, which are more fully developed in Attachment A:

The Federal government must not abrogate or transfer to the states its responsibility for the long term health care needs of Medicaid recipients as part of a Federal budget reduction without developing adequate assurances that those individuals will receive the services they need.

Acticn to reduce the growth of Medicaid expenditures should be equitable. No group of beneficiaries or providers should be unfairly singled out to absorb disproportionate loss of Federal support.

The budget reductions must be accompanied simultaneously by supportive legislative and regulatory changes which allow state governments and providers greater flexibility in providing more cost-effective care and minimize adverse effects on beneficiaries.

In developing specific proposals for implementing budget savings, attention should initially be focused on regulatory reform proposals, i.e., elimination of current requirements (1) where the costs of compliance outweigh the benefits, (2) which do not relate to patient care, or (3) which restrict the state's ability to develop cost effective programs to meet their needs.

The Federal government must seek budget savings in the Medicare program which absorbs a much greater share of the Federal budget than Medicaid and employs less efficient reimbursement policies.

The Administration's proposals, as we understand them, fail to adhere to these principles in two important areas. Medicare, particularly Medicare reimbursement, an inherently inflationary mechanism, is exempted from budget savings. Also, the Department of Health and Human Services has eschewed overhaul of the statutory and regulatory obstacles to efficient management of the program by state governments in favor of a liberal blanket waiver of state initiatives.

AHCA endorses the National Governors' Association's call for reform of Medicare reimbursement. We agree with the governors that the Federal government could limit the spiraling growth of health care costs by the employment of a well-designed prospective reimbursement methodology in Title XVIII. AHCA is currently conducting a study of the potential impact of the use of prospective reimbursement for skilled nursing facilities participating in Medicare. As you know, Medicare utilizes an inefficient and inflationary retrospective reimbursement system. We believe we can prove that a prospective system will expand skilled nursing services, reduce the need for patients to remain in a costly hospital bed because a SNF bed is not available, and limit both the cost of the individual's care and the overall expense of the Medicare program.

AHCA is surprised that the Administration is apparently attempting to live up to its promise of greater state flexibility in the Medicaid program by reliance on waivers, rather than by specific statutory and regulatory amendments. While the Secretary of Health and Human Services appears to be genuinely committed to more autonomy for the states, the waiver authority he envisions will counteract this freedom by re-establishing the authority of Federal governments to veto state initiatives. Moreover, it would appear to exclude the Congress from a role determining which aspects of the program are to be eliminated and which are to be retained in the interest of efficiency.

AHCA believes that the Administration and the Congress should directly address the programmatic aspects of the Medicaid cuts, rather than promising the states sympathetic consideration of their initiatives. We recommend that the following proposals be adopted by the Congress to achieve savings in Federal outlays for Medicaid:

Provide the states with authority to develop cost-effective reimbursement policies for all providers similar to the recent changes in nursing home reimbursement effected by Public Law 96-499.

Curtail "Freedom of Choice" legislation, permitting states to achieve greater program savings in purchase of health care services and medical equipment.

Encourage the states to reasonably restrict "medically needy" eligibility by withholding Federal payments for higher income recipients.

Amend Federal laws to permit states to develop innovative cost savings programs such as co-payments and family supplementation.

We also recommend the following initiatives for achieving greater cost savings and efficiency in the long term care component of Medicaid:

Redesign Federally mandated survey and certification procedures for maximum efficiency.

Revise regulations and eliminate those which are not cost effective or do not relate to patient care.

Simplify utilization review.

Develop programs to place patients in the least costly setting to meet their health care needs.

(Note: The above described in more detail in Attachment B.)

We believe that the above would provide maximum freedom for the states to achieve savings in the Medicaid program without curtailing basic entitlements or services.

AHCA opposes the National Governors' Association's (NGA) alternative proposal to restrict Federal Title XIX expenditures for long term care services. The NGA bases its initiative on the inaccurate assumption that nursing home services are the most rapidly growing component of Medicaid costs.

Data of the Department of Health and Human Services contradict the NGA assertion that nursing home services are the most rapidly rising component of Medicaid costs and indicate that the growth is attributable to treatment of the mentally ill and retarded in Intermediate Care Facilities for the Mentally Retarded (ICF-MR). The data indicate that in 31 states the estimated percentage of the Medicaid budget consumed by nursing home services (other than ICF-MR) will decline during the period from fiscal year 1978 to fiscal year 1982. However, if ICF-MR services are included only 19 states decrease the percentage of the budget which goes to long term care services. Moreover, the estimated nationwide percentage of Medicaid expenditures going for nursing home services will decline slightly (2.8 percent) during the same period if ICF-MR is excluded but will increase 1.7 percent if ICF-MR is included. The states are largely responsible for this increase as a result of their policies to "deinstitutionalize" state supported mental institutions and to place these individuals in ICF-MRs and nursing homes funded by Medicaid.

Studies have indicated that growth of nursing home expenditures are also due primarily to increased utilization and general inflation. Nursing home services are one of the few services covered by Medicaid which can attest to the increased utilization as having a significant impact on the growth of expenditures. The elderly population in need of these services has been increasing and is projected to expand in future years.

AHCA maintains that Medicaid nursing home care is very cost effective. It should be noted that states have successfully employed prospective reimbursement systems for nursing homes for several years in order to contain costs. Medicaid reimbursement to nursing homes is unique in that historically states have a considerable amount of flexibility and latitude in developing payment methodologies for nursing home services. Since the inception of the program, states have had the great flexibility to develop efficient nursing home reimbursement methodologies.

As a result of this flexibility, in 1977 states began developing and implementing prospective reimbursement systems with built-in cost containment mechanisms and incentives, such as cost center limits and ceilings on payment rates. Currently, thirty-eight states employ prospective reimbursement; forty-eight states establish various ceilings on costs; twenty-four states impose overall rate limits; thirty-three states have cost center ceilings; and thirty-four states offer incentives for efficient providers.

These systems have been successfully employed to contain nursing homes' costs and typically result in payments to providers that are lower than their costs of serving needy Medicaid patients. As a result of these systems with their cost containment mechanisms, payments to nursing homes have been restrained. It should also be noted that a recent amendment to the Medicaid law provides states additional flexibility and latitude in establishing prospective reimbursement systems and determining payments to nursing homes.

Medicaid nursing home cost increases have been limited to increases attributable to inflation, greater utilization and costly state regulations. These costs have grown approximately 15 percent per year in recent years largely because of inflation. The NGA maintains, however, that the state governments could convert a block grant for the long term care portion of the Medicaid program, capped at 7 percent in fiscal year 1982, into a more comprehensive system of services, including non-institutional care.

To apply a cap and block grant solely on long term care would be to single out one group of beneficiaries to bear the burden of reduced Federal support which is contrary to the Administration's objective of equitable sacrifice. In addition, to the extent that nursing home services are not provided and non-institutional services

are not available, recipients will be forced to remain in more costly hospitals which will increase expenditures in that area.

[Attachment A]

IMPLICATIONS OF THE BUDGET REDUCTIONS ON LONG TERM CARE PROGRAMS

NEEDS OF BENEFICIARIES

AHCA believes that it would be tragic for the Federal government to abrogate or to transfer to the states its responsibility for the long term health care needs of Medicaid recipients as part of a Federal budget reduction, without developing adequate assurances that these individuals will receive the services they need.

Nursing homes are the principal institutions for delivery of long term care for the elderly and handicapped. Home health and support services are an alternative to institutional care but these programs are haphazardly funded by the Federal government and are unavailable in many parts of the country. Medicaid and to a much less degree, Medicare, are the principal Federal funding mechanisms for care inside a nursing home. Federal support of home health and support services is less extensive and less concentrated, involving Titles XVIII, XIX and XX.

We advocate the development in the community of a mix of facility and home based services tht will permit delivery of care in the most appropriate setting. We are concerned, however, that some states will leap into lower cost home health programs and withdraw funding for care in long term care facilties to the detriment of Medicaid recipients of institutional care, if Federal funds are cut back and states are given discretion to do so. Perhaps 10 percent of all residents in nursing homes could be cared for in a community based setting if appropriate services were available. Many residents in nursing homes, particularly those covered by Medicaid do not have homes or living relations that would permit them to take advantage of home health care programs. An increasing number of residents supported by Medicaid are the "frail elderly" who are severely debilitated and could not function outside an institutional setting, except through massive expenditures for care.

The Federal government established the patterns of long term care delivery by its categorical requirements in both Title XVIII and XIX. If the patterns of delivery are to be restructured, the states must be given maximum flexibility to assess needs and package delivery systems, but the Federal government has a responsibility to insure that current recipients are not disenfranchised and that long term care services are available to entitlement recipients who need them.

REQUIREMENTS OF PROVIDERS

Both the Federal and state governments have a stake in maintaining the viability of health care providers when they cut back on Medicaid funding. Hospitals, physicians, nursing homes, home health agencies—all provide necessary services to the community.

Modern nursing homes are largely the product of a public demand, generated by the creation of Title XVIII and Title XIX. Nearly 50 percent of all long term care facility residents are funded by Medicaid. Another 4 percent are funded by Medicare. Nursing home construction, life and fire safety devices, staffing, and administration are mandated by Federal or supplementary state regulations.

Unlike hospitals, nursing homes are primarily (80 percent) for-profit corporations. They are labor intensive businesses with a median size of 100 beds and employing over one hundred staff members as an average. General inflation and Federally mandated requirements such as minimum wage increases and compliance with life safety codes have greatly increased the cost of maintaining a nursing home.

Despite the increases in expenses, the cost of nursing home services (i.e. nursing care, social programs, room and board) have been held to a reasonable level in recent years. The expansion of nursing home costs in the Medicaid program is a result of increased utilization resulting from a growth of the elderly population needing long term care, eligibility criteria adopted by the states and a shift of expenditures for the care of the mentally ill and retarded from state programs to Medicaid, as well as the proliferation of excessive government regulations unrelated to patient care. Despite these increases, most state Medicaid plans have stringent controls on the per-patient charges for Medicaid nursing home services through the use of prospective reimbursement methods with built-in containment features, plus incentives for efficiency. A provision in the recently enacted 1980 Omnibus Reconciliation Act (Public Law 96-499) was specifically designed to increase state flexibility for developing cost-effective Medicaid nursing home rates.

Drastic reduction in Medicaid reimbursement to nursing homes will have the effect of lowering the quality of care or restricting bed availability for Medicaid

patients, unless the administrative and regulatory requirements required by the Federal government are simplified and streamlined. Providers can furnish care at lower costs if they are given freedom, within reasonable limits, to produce cost savings. Expansion of prospective systems to all state Medicid programs would further reduce program costs, particularly if providers are permitted to keep part of the cost savings as an incentive for efficiency.

THE MEDICARE-MEDICAID CONNECTION

The Reagan Administration has targeted Medicaid for reduction of Federal outlays, but has exempted Medicare as part of the social safety net. Federal Medicare outlays are projected at over $40 billion in fiscal year 1982; Medicaid outlays at $18.2 billion. AHCA agrees that Medicare benefits are an essential component of the well-being of our senior citizens. We also point out that Medicaid coverage for long term care services, particularly for those recipients without families or other means of support, is an equally valuable component of the social safety net.

AHCA does not believe that current Medicare reimbursement or regulatory policies are efficient vehicles for the delivery of care to beneficiaries needing acute or long term care. Medicare's retrospective "reasonable-cost" reimbursement policies are inflationary and do not impose either incentives or disincentives for cost-effective delivery of care.

Title XVIII policies have had a pernicious effect on long term care. Nursing home operations have dropped out of Medicare in droves because of excessive administrative requirements, low utilization created by arbitrary Federal policy, and retrospective denial of reimbursement. Medicare policies have also had a harmful effect on the Medicaid program. Several states have adopted Medicare principles of reimbursement with little opportunities for cost savings by the government other than ruthless denial of charges for service rendered and concomitant provider uncertainty and resentment.

AHCA implores the Administration and the Congress not to uncritically reject Medicaid and endorse Medicare. Medicaid long term care reimbursement and regulatory policies are more cost-effective than their Medicare counterparts. Adoption of the former for all institutional providers participating in either Title XVIII or XIX programs would drastically reduce Federal health care expenditures without affecting benefits for recipients.

[Attachment B]

SPECIFIC BUDGET REDUCTION RECOMMENDATIONS

DEVELOPMENT OF COST EFFECTIVE PROVIDER REIMBURSEMENT POLICIES

AHCA believes that the recent changes in nursing home reimbursement effected by Public Law 96-499 can serve as a model for removal of impediments for states to develop cost effective reimbursement methodologies. Section 962 of Public Law 96-499 often referred to as the "Boren Amendment," provides that states must reimburse nursing homes based on rates that are adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in accordance with mandated requirements and standards. Within this broad statutory requirement, states have the flexibility to develop their own methodology for establishing rates based on the unique needs within the characteristics of the state. In fact, the principle purpose of the amendment was to provide states additional flexibility in determining reimbursement to nursing homes.

Although states have been given considerable flexibility and latitude, the amendment also requires that states provide assurances to the federal government that the rates are adequate and satisfy the statutory requirement. Thus, the states have obtained sufficient flexibility while the federal government has retained appropriate authority to ensure that its minimum requirements are met. This approach to reimbursement for nursing homes could serve as a model for other providers and other aspects of the program as well as fitting within the overall framework of the Medicaid program AHCA recommends—retain Medicaid as an entitlement program but permit maximum state flexibility in determining eligibility, services, and reimbursement.

Medicaid reimbursement to nursing homes is unique in that even prior to the additional flexibility provided by the "Boren Amendment," states had a considerable amount of flexibility in developing reimbursement methodologies for nursing homes. For several years states have used this flexibility to control the per patient day costs of nursing home services through the employment of prospective reimbursement plans with built in cost containment mechanisms, such as cost center limits and ceilings on payment rates. AHCA earnestly believes that as a result of

these systems with their cost containment mechanisms and the unrealistically low reimbursement rates which preceded these systems, payments to nursing homes are not excessive and contain "very little fat" controllable by a facility. To assume that payment rates to nursing homes could be significantly reduced without having a detrimental impact on quality of care would be a tragic mistake.

CURTAILMENT OF FREEDOM OF CHOICE

Under the existing freedom of choice statutory provision and implementing regulations, the only services which are amenable to volume purchasing are eyeglasses, hearing aids, prescribed drugs and durable medical equipment. Last year, a provision was introduced (and subsequently dropped) in the omnibus reconciliation bill limiting freedom of choice for beneficiaries obtaining services and supplies under Medicaid. The intent of this provision was to enable states to achieve greater savings through bulk purchases of services. The states were to be limited in this only to the extent that the restrictions on freedom of choice were cost-effective, assured reasonable access to services, and avoided substantially adverse effect on access to teaching hospitals.

AHCA supports curtailment of freedom of choice to permit state governments the opportunity to negotiate competitive prices for provider services and vendor goods, provided there are safeguards to prevent the use of this provision to exclude participation by providers or vendors for any other reason than non-competitive prices.

GREATER STATE COST SAVINGS FLEXIBILITY

Federal laws should be amended to permit states to develop innovative cost savings program.

Several states have sought authority to introduce cost savings measures in the Medicaid program. Last year the Alabama Congressional delegation introduced legislation permitting family supplementation, copayments and greater authority to crack-down on program abusers. Massachusetts is currently exploring a negotiated rate purchase system with groups of providers.

The Administration has promised to develop a comprehensive health care reform package which would reduce the growth of health care costs. While work on that initiative goes on, states should be permitted maximum flexibility to develop cost-effective systems by the elimination of Federal legislative and regulatory restrictions.

RESTRICTING ELIGIBILITY

One approach to reducing Medicaid expenditures is to address the issue of increasing utilization by imposing stricter limits on eligibility for benefits. Eligibility could be tightened up in an effort to ensure that only the "truly needy" are receiving benefits.

For example, the income standard to qualify as a "medically needy" recipient could be reduced. The medically needy are generally people whose incomes are too high to receive cash assistance (e.g., SSI, AFDDC) but who cannot afford to pay their medical bills. The amount of their incurred medical expenses must equal or exceed the amount of income they have above the state income level. Each state with a medically needy program (over half the states) sets income levels for determining eligibility of the medically needy. The level at which these income standards are set could be reduced so that only the "truly needy" are covered.

Another approach, which has been proposed by the Congressional Budget Office, is to eliminate from coverage as "categorically needy" individuals who only receive optional state supplements. The categorically needy are generally individuals who are eligible for Medicaid because they can meet the income requirements for cash assistance, regardless of the extent of their medical bills. However, thirty-four states also have elected to include in the categorically needy group persons whose income disqualifies them for federal SSI payments but who receive state supplements. That is, these individuals do not receive federal cash assistance, but receive state supplements and are entitled to Medicaid benefits as the categorically needy group. The Congressional Budget Office has estimated that a savings of $320 million could be realized in the first year if these individuals no longer receive Medicaid benefits as categorically needy. The five year savings was estimated to be almost $2 billion. It was further estimated that elimination of this coverage would eliminate or reduce Medicaid benefits for about 600,000 persons. However, the "truly needy" would continue to receive benefits because those individuals living in states with coverage for the medically needy could continue to receive benefits if they had sufficient medical expenses.

SURVEY AND CERTIFICATION REFORM

A poll of AHCA members last year revealed that long term care facilities are surveyed an average of ten times each year. Each survey involved approximately three government inspectors and takes the full time of three to five facility staff members. We believe that the survey process is an expensive administrative process.

Immediate changes could save program administration costs, free facility staff for patient care activities, and reduce expenditures for unneeded correction plans. Such changes include:

Combining all the federally mandated surveys into one. We see no reason why an inspection of care team, certification team, Professional Standards Review Organization team and Health Planning team (for appropriateness review) all must review essentially the same components of long term care facilities.

Extend provider agreements. Facilities performing well could be reviewed every two years rather than annually if provider agreements could be made for twenty-four months. This way, survey teams could concentrate their efforts of facilities having numerous deficiencies.

Revise the survey report form. Currently, inspectors survey five hundred twenty separate items in skilled nursing facilities. We suggest that this form be cut back to only statutorily required and other elements critical to the provision of health care.

Improve survey training so that all inspectors know the standards and can recommend cost effective corrections. Misinterpretation and surveyor private interpretation of rules account for large expenditures, eventually billed to the Medicaid program. One AHCA facility replaced five doors five times because each successive inspector had a different idea of fire door requirements.

REVISE REGULATIONS AND ELIMINATE THOSE WHICH ARE NOT COST EFFECTIVE OR DO NOT RELATE TO PATIENT CARE

The skilled and intermediate care facility conditions of participation contain numerous provisions that are either not cost effective and/or not related to patient care. These rules relate to committee meetings, recordkeeping requirements and other activities. The interpretive guidelines accompanying the nursing home standards frequently impose additional requirements. For example, regulations requiring "timely visits" by consultants are translated in the guidelines to five hours per week. We suggest that the conditions of participation and guidelines be reviewed and rewritten in an outcome oriented, rather than process oriented fashion. This regulation reform would result in more efficient use of nursing home staff.

Some examples of rules we believe should be reviewed include:

Frequency of physician visit—Regulations mandate that physicians must visit patients every 30 or 60 days, whether or not the patients' conditions warrant a physician visit. We suggest rules be revised to require visits based on patient need, an allowance of nurse practitioner and physician assistance visits (under general physician supervision) in lieu of physician visits. This change would reduce physician Medicaid costs, not facility costs.

Committees: The pharmaceutical, infection control and utilization review committees, each necessitating numerous professional's attendance, could be eliminated if their functions could be accomplished more efficiently.

Consultants: Highly qualified consultants are required in skilled facilities whether or not department performance shows a need for consultants. These includes: medical records administrators, social workers, dieticians, advisory dentists, activity consultants.

Patients' rights—Interpretive guidelines far exceed the regulations. For example, guidelines require that patients who are wearing safety devices be observed every 30 minutes and that observation must be documented.

Since federal nursing home rules apply to facilities with both Medicare and Medicaid patients, the potential savings realized would apply to both the Medicare and Medicaid programs. We believe that these measures would effectively control the growth of long term health care costs (but not necessarily lead to immediate cost savings).

A second step-in regulation reform must be directed at the state level. The federal government portion of Medicaid payment must cover state as well as federal rules. These state standards often far exceed federal rules, especially in the areas of staff qualification, numbers of staff, and reporting requirements.

Two approaches could be directed at curbing the growth of health care costs as a result of state rules:

Disallow costs related to state requirements from the federal Medicaid match. In this option, the federal government would not pay for state imposed standards beyond federal requirements.

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If federal payment for state standards is continued, require states, as a condition of being part of the Medicaid program, to establish mechanisms to review the cost and necessity of their rules. These mechanisms could be similar to those mandated on the federal level by Executive Order 12291, (regulation reform), the Regulatory Flexibility Act (for small entities), and the Paperwork Reduction Act.

SIMPLIFIED UTILIZATION REVIEW

Utilization review in long term care facilities, the system of assuring that each Medicare and Medicaid patient needs the services being given, is an expensive and burdensome Medicaid requirement. We believe it is not worth the Medicaid dollars now spent. Typically, it involves three activities: (1) Each attending physician must visit Medicaid patients either monthly or bimonthly in order to certify the need for continued care, (2) Facilities hold monthly meetings with administrative and nursing staff and three private physicians in attendance to review physician certification and continued need for care; (3) At least annually, an inspection of care team visits each facility to inspect the record of each public pay patient. (These visits often involve several weeks of daily facility attendance with three or more health professionals. This survey is paid in full by the Federal government.)

This process could be greatly simplified and made less costly to the Medicaid program if:

Greater attention was given to patients entering the long term care system and less attention to those already placed in facilities. A good assessment prior to admission could reduce unnecessary placements.

Patients with little discharge potential were reviewed less frequently than is now required. If discharge is not expected for at least six months, review should not be necessary for six months.

Patients with no discharge potential were not reviewed. In some instances, especially in the case of the terminally or progressively ill, utilization review is only a paper exercise.

Mail, telephone and other expedient review procedures replaced physician visits, meetings, and on-site review. The Iowa Professional Standards Review Organization has found these procedures to be extremely cost efficient.

Physician assistants and nurse practitioners (as well as physicians) could certify the need for care.

Combine the three review activities into a single, binding review process.

CONSIDER SHIFTING PLACEMENT OF PATIENTS FROM MORE COSTLY TO LESS COSTLY HEALTH CARE SETTING

Nursing home Medicaid expenditures must not be viewed in a vacuum. The provision of long term care is actually performed along a continuum, in various locations—from services rendered in the home to services provided in acute care hospitals. These services may be paid for by the Medicare, or by other federal programs. We believe that services should be delivered in the most cost effective setting that meets the patient's needs. We suggest that funds expended through Medicaid be viewed in relation to the overall government dollars spent in providing long term care. Reduction of Medicaid nursing home disbursements will have the effect of raising Federal long term care costs in other programs, usually at a higher level of expenditure.

The community long term care facility is the most cost-effective source of health care for individuals in need of the services provided in these facitilities. We wish to bring to your attention:

When the Veterans Administration places a veteran in a community nursing home, the cost of that care is less than over half of what it would cost in a long term care Veterans Administration facility. Still the VA is planning on converting or building thirty-two nursing home facilities in the near future.

State mental institutions cost two to four times as much to care for a patient as would a community long term care facility. Some chronically mentally ill patients currently in state institutions could be adequately cared for in general community nursing homes. Others could be cared for if community long term care facilities were permitted to specialize in the care of the chronically mentally ill. However, present law excludes Medicaid reimbursement for certain age groups when such specialization exists.

Likewise state institutions for the mentally retarded are far more costly than most long term care facilities. Current rules require that facilities for the mentally retarded all have similar program standards, whether or not all patients could benefit from such programs. If program requirements were based on the patient needs and potential rather than blanket standards, cost savings would be realized.

Some hospitals are gradually becoming long term care facilities because community nursing home placement for patients is not available. Large numbers of patients are receiving acute care (at acute care prices) when they need long term care (at approximately a quarter of the cost). During 1980, the American Association of Professional Standard Review Organizations conducted a one day survey of patients awaiting nursing home placement. The 101 PSROs reported a total of 17,783 patients awaiting placement on one single day. A reason for this "back-up" is resistance of long term care providers to participate in the Medicare program because of numerous problems inherent in this program.

We believe that the hospital back-up problem will continue and that its toll on Medicare and Medicaid programs will escalate. A reason is that many states are trying to control (or cap) their long term care expenditures by prohibiting the building of long term care facilities and the addition of beds. We see this as a shortsighted solution to a complex problem.

TESTIMONY OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman, I am David C. Crowley, Executive Vice President of the American Association of Homes for the Aging. Accompanying me this morning is Laurence F. Lane, Director for Public Policy of the association.

The American Association of Homes for the Aging represents the not-for-profit providers of facility-based services to older Americans. Among our nearly 2,000 members are facilities which participate in the Title XVIII (Medicare) program as skilled nursing facilities and in the Title XIX (Medicaid) program as skilled nursing facilities and intermediate care facilities. A number of our member homes are involved in housing, health-related shelter and community outreach services which include day care, home health and nutrition services.

We come before this committee today to address the impact of the proposed budget reductions in the Medicare and Medicaid programs and to suggest alternative approaches which should be carefully considered by members of the committee. Our association has an extensive statement which I request permission to enter into the Record. I shall read a synopsis highlighting the key areas.

At the outset, let us emphasize that our remarks are guided by three key principles:

Public assistance should be provided to individuals who are in the greatest need. Need has both a functional and an income definition.

Medicaid in fact constitutes a catastrophic health program for older Americans. It is an integral component of the social safety net protecting the general welfare of the elderly.

Major systemic changes in the structure of the Medicare and Medicaid programs should not be made in the haste of the budgetary debate. Cost-savings should be extracted from incremental program changes. Major program reforms should be deferred until a complete analysis can be completed and consideration can be given to the implementation strategy.

I. IMPACT OF THE MEDICAID REDUCTIONS

Among the most important of the proposed budget revisions recommended by President Reagan in his program for economic recovery are limits on the Medicaid program. Stringent restrictions of Medicaid expenditures will undermine our efforts to improve the quality of life for older persons. While supportive of our President's promised efforts to revitalize the economy, AAHA questions whether the "social safety net" for the elderly, unemployed and poor can be secured without vigorous federal support of Medicaid. While changes must be made in both Medicare and Medicaid to make them more responsive to the needs of older Americans and controllable as government expenditures, we strongly believe that the dismantling of Medicaid would be a counter-productive policy.

There is false economy in advocating reductions in Medicaid without considering the eventual impact upon Medicare. Demand for long term care services already has created a tremendous backlog in hospitals. Medicaid reductions will further encourage providers not to serve the poor, thereby putting greater strain upon the social services system to support individuals not being assisted otherwise. Health policy should not suggest that Medicare meets the needs of the elderly and Medicaid does not. Both programs are complementary components of the "social safety net."

While it is difficult to project the response of the states to a specific cap on expenditures for Medicaid, it is fairly clear that sizable program reductions would be required. It seems somewhat ironic that the current director of the Office of

Management and Budget responded to a proposed limitation on hospital expenditures during the past Congress by pointing out:

Attempting to cap the system without changing the fundamental incentives of patients and physicians ordering services will only ensure that the quality of the product declines.

. On this particular point, we find ourself in agreement with Mr. Stockman, and we suggest that a closed-end approach to Medicaid will only translate into a deterioration of services to indigent persons. Furthermore, because the proposed approach does not carefully analyze the interactions between Medicare and Medicaid with respect to the provision of services to the aged and the totally and permanently disabled, there are numerous opportunities for costs to be passed back to the federal government, thus circumventing the cost containment thrust.

II. COST-SAVING APPROACHES

As suggested above, we believe savings can best be secured, in the short-run, from incremental changes in the Medicare and Medicaid program. We believe a balanced strategy can equalize the impact of reductions without jeopardizing options for significant policy reforms in the delivery of health care services. Changes only in Medicaid will have the greatest impact on those most in need and might lead to an exploitation of Medicare to assume responsibilities beyond its program resources. The best protection for older Americans comes through a balanced approach which makes incremental changes in both Medicare and Medicaid. In fact, we would argue that given the catastrophic protection afforded to older persons through the interaction of Medicare and Medicaid, that program reductions in Medicare will have the least devastating effect.

In our written statement, we identify 25 areas for possible cost savings under the Medicare and Medicaid programs. Our recommendations are set forth in five broad areas:

Modifying reimbursement methods for providers

Increasing the share of costs borne by program beneficiaries

Reducing unnecessary utilization

Promoting more cost-effective providers

Improving program administration

Among the key areas for prudent reductions in the costs to the Medicare and Medicaid programs are the following:

We believe that modest cost-savings can be secured through reasoned modification of a number of reimbursement methods used in the current programs. As suggested above, we believe a major weakness of the budget proposal advanced by President Reagan is its failure to address the skewing of health care expenditures toward acute care. As long as hospital reimbursement is based upon a cost-plus basis, and containment is focused on all other components of the delivery system, there will be an ever-increasing bias to use the highest cost service.

We believe there is merit in extending the provisions of Section 901 of Public Law 96-499 to all health services. Section 901 clarifies the incentives for hospital philanthropy. Clearly, the community involvement, especially in long term care services sponsored by nonprofit organizations such as visiting nurse services and religious sponsored homes, could augment public expenditures through ambitious philanthropic campaigns.

While we emphatically oppose use of a means test for Medicare, we are mindful that the utilization of Medicare benefits provides limited incentive for consumer discretion. We believe it is possible to increase the Medicare Part B deductible in a two-step process, from $60 to $75 in 1982 and then $100 in 1983, and cost-indexing the amount for future years. The deductible has not been raised since the 1972 amendments. Costs of services have escalated significantly during that period, raising a number of beneficiaries beyond the Part B threshold. The increase in the deductible could make Medicare users more cost-conscious. For individuals in the greatest economic need, the Medicaid buy-in of Medicare services protects them from the dollar increase of the deductible. Given a continuation of the cost-indexing of income maintenance strategies and a continuation of the buy-in provisions under Medicaid for Medicare recipients, we believe a modest adjustment of the Part B deductible would not be a devastating policy course. To ensure that such a reduction does not force hardship, we would prefer the continuing policy of considering expenditures during the previous three months for carryover calculation of the annual deductible.

As we have stated to Congress in previous testimony, one of the major weaknesses of our current policy toward the elderly is our neglect to provide a realistic spectrum of living arrangements. We would encourage the Congress to increase the level of significance given to Section 1616(e) of the Social Securty Act, encouraging states

to stem the use of intermediate care facilities while expanding the use of "social care" facilities providing protective oversight and congregate supports to persons defined as at-risk and in need of specialized living arrangements. The SSI provision could be expanded with a concomitant restructuring of the intermediate care facility benefit and intermediate/mental retardation benefit to more uniformly conform service provision among the states.

Committee attention should be directed to the relationship of private insurance to the public benefit. Neglect of this area at the federal level has permitted a shifting of costs from the private sector to the public sector. Medicare has become the primary insurer for the disabled and aged, with an abdication of responsibility by the private market. Obviously, this abuse of the public sector should be stemmed. We are supportive of approaches considered by the Finance Committee in past sessions to ensure that primary coverage comes from insurance and third party payers. A special case has been made for older workers who continue in their employment. Perhaps the time has come for Congress to phase in requirements to shift the first dollar health protection for such individuals to the private sector. A phased-in transition should be implemented to ensure that the disadvantages of underwriting such insurance protection do not become disincentives for an employer to continue the services of an older worker.

For the elderly, the medically needy category is of great importance. It constitutes the catastrophic protection which is a major component of the social safety net. Under the Medicaid program, however, some states have abused the availability of federal matching funds to expand their eligibility limits. Obviously, in a period of retrenchment, there should be a move toward standardizing the parameters of the categories and medically needy classifications. Rather than increase the state discretion in this area, we believe the federal interest is better served by phasing in standard limitations. States should be permitted to provide supports above limits at their own expense. Such a uniform approach would be helpful in constructing a public spending floor as a component of any competitive health care model. At the same time, we point out to the committee that the budget information does not indicate savings from changes in accounting for eligibility in the categorical programs. We seriously question whether a retrospective accounting methodology as proposed might not be punitive for potential SSI recipients living in long term care facilites. We believe only a prospective accounting system can prevent hardships from occurring.

III. CONCLUSION

We believe these numerous options for containing escalating program costs are preferable to a wholesale change in the framework of Medicare and Medicaid. Our message is clear: we would prefer to see incremental changes now and a time schedule established for reviewing systemic changes following the pressures of the budgetary debate. There is a need to alter the Medicare and Medicaid programs and to improve our service system to meet growing human needs in a cost-efficient manner. However, to make those changes during these emotion-filled debates on economic recovery is to shortchange the American public.

Our association stands ready to assist the committee in evaluating various approaches to cost savings and to work with members of the committee in improving the responsiveness of our public programs to the needs of older Americans.

KEY POINTS OF AHCA'S TESTIMONY

AHCA endorses the following amendments in the Medicaid program which would reduce expenditures without damaging delivery of basic services:

1. Provide the states with authority to develop cost-effective reimbursement policies for all providers similar to the recent changes in nursing home reimbursement effected by Public Law 96–499.
2. Permit states to achieve greater program savings in purchase of health care services and medical equipment by amending present law (i.e. amend freedom of choice).
3. Encourage the states to reasonably restrict "medically needy" eligibility by withholding federal payments for higher income recipients.
4. Amend federal laws to permit states to develop innovative cost savings programs such as co-payments and family supplementation.

AHCA endorses the following intitiatives to achieve efficiency in Medicaid long term care services:

1. Redesign federally mandated survey and certification procedures for maximum efficiency.

2. Revise regulations and eliminate those that are not cost effective or do not relate to patient care.
3. Simplify utilization review.
4. Develop programs to place patients in the least costly setting that meets their health care needs.

AHCA opposes the DHSS proposal to give states flexibility to achieve program savings through waivers, which are arbitrary and bureaucratic. AHCA reommends that the Congress enact statutory changes to allow states to realize reduction of expenditures.

AHCA supports the National Governors' Association's (NGA) Initiative to obtain some of the savings earmarked for Medicaid by implementing prospective reimbursement policies in Medicare. AHCA strongly opposes the NGA's proposal to cap only long term care in Title XIX.

STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION

The American Health Care Association (AHCA), which represents 7,500 nursing homes nationwide, supports the efforts of the Administration and the Congress to restore the viability of the American economy by reducing the growth of the Federal budget. Our members, their employees and the residents that they serve, have felt the sting of inflation. We are committed to working with the Administration and the Congress to find a cure for this economic disease.

Nursing home providers, however, like the members of the Senate Finance Committee, also have a duty to assess the impact of budget cutting on the elderly and handicapped—our mutual constituents. The President has proposed to reduce Medicaid funding by $1 billion in fiscal year 1982 and to cap Federal Medicaid expenditures in future years. Nearly 50 percent of the residents of nursing homes are supported by the Medicaid program nationwide. Sustained budget reductions of the magnitude proposed by the Administration may have a harmful impact on the availability and quality of long term care services for the poor, unless they are carried out in a responsible and equitable manner.

AHCA believes that any reduction of Medicaid funding should adhere to the following basic principles, which are more fully developed in Attachment A:

The Federal government must not abrogate or transfer to the states its responsibility for the long term health care needs of Medicaid recipients as part of a Federal budget reduction without developing adequate assurances that those individuals will receive the services they need.

Action to reduce the growth of Medicaid expenditures should be equitable. No group of beneficiaries or providers should be unfairly singled out to absorb disproportionate loss of Federal support.

The budget reductions must be accompanied simultaneously by supportive legislative and regulatory changes which allow state governments and providers greater flexibility in providing more cost-effective care and minimize adverse effects on beneficiaries.

In developing specific proposals for implementing budget savings, attention should initially be focused on regulatory reform proposals, i.e. elimination of current requirements (1) where the costs of compliance outweigh the benefits, (2) which do not relate to patient care, or (3) which restrict the state's ability to develop cost effective programs to meet their needs.

The Federal government must seek budget savings in the Medicare program which absorbs a much greater share of the Federal budget than Medicaid and employs less efficient reimbursement policies.

The Administration's proposals, as we understand them, fail to adhere to these principles in two important areas. Medicare, particularly Medicare reimbursement, an inherently inflationary mechanism, is exempted from budget savings. Also, the Department of Health and Human Services has eschewed overhaul of the statutory and regulatory obstacles to efficient management of the program by state governments in favor of a liberal blanket waiver of state initiatives.

AHCA endorses the National Governors' Association's call for reform of Medicare reimbursement. We agree with the governors that the Federal government could limit the spiraling growth of health care costs by the employment of a well-designed prospective reimbursement methodology in Title XVIII. AHCA is currently conducting a study of the potential impact of the use of prospective reimbursement for skilled nursing facilities participating in Medicare. As you know, Medicare utilizes an inefficient and inflationary retrospective reimbursement system. We believe we can prove that a prospective system will expand skilled nursing services, reduce the need for patients to remain in a costly hospital bed because a SNF bed is not available, and limit both the cost of the individual's care and the overall expense of the Medicare program.

AHCA is surprised that the Administration is apparently attempting to live up to its promise of greater state flexibility in the Medicaid program by reliance on waivers, rather than by specific statutory and regulatory amendments. While the Secretary of Health and Human Services appears to be genuinely committed to more autonomy for the states, the waiver authority he envisions will counteract this freedom by re-establishing the authority of Federal governments to veto state initiatives. Moreover, it would appear to exclude the Congress from a role determining which aspects of the program are to be eliminated and which are to be retained in the interests of efficiency.

AHCA believes that the Administration and the Congress should directly address the programmatic aspects of the Medicaid cuts, rather than promising the states sympathetic consideration of their initiatives. We recommend that the following proposals be adopted by the Congress to achieve savings in Federal outlays for Medicaid:

Provide the states with authority to develop cost-effective reimbursement policies for all providers similar to the recent changes in nursing home reimbursement effected by Public Law 96-499.

Curtail "Freedom of Choice" legislation, permitting states to achieve greater program savings in purchase of health care services and medical equipment.

Encourage the states to reasonably restrict "medically needy" eligiblity by withholding Federal payments for higher income recipients.

Amend Federal laws to permit states to develop innovative cost savings programs such as co-payments and family supplementation.

We also recommend the following initiatives for achieving greater cost savings and efficiency in the long term care component of Medicaid:

Redesign Federally mandated survey and certification procedures for maximum efficiency.

Revise regulations and eliminate those which are not cost effective or do not relate to patient care.

Simplify utilization review.

Develop programs to place patients in the least costly setting to meet their health care needs.

(Note: The above are described in more detail in Attachment B.)

We believe that the above would provide maximum freedom for the states to achieve savings in the Medicaid program without curtailing basic entitlements or services.

AHCA opposes the National Governors' Association's (NGA) alternative proposal to restrict Federal Title XIX expenditures for long term care services. The NGA bases its initiative on the inaccurate assumption that nursing home services are the most rapidly growing component of Medicaid costs.

Data of the Department of Health and Human Services contradict the NGA assertion that nursing home services are the most rapidly rising component of Medicaid costs and indicate that the growth is attributable to treatment of the mentally ill and retarded in Intermediate Care Facilities for the Mentally Retarded (ICF-MR). The data indicate that in 31 states the estimated percentage of the Medicaid budget consumed by nursing home services (other than ICF-MR) will decline during the period from fiscal year 1978 to fiscal year 1982. However, if ICF-MR services are included only 19 states decrease the percentage of the budget which goes to long term care services. Moreover, the estimated nationwide percentage of Medicaid expenditures going for nursing home services will decline slightly (2.8 percent) during the same period if ICF-MR is excluded but will increase 1.7 percent if ICF-MR is included. The states are largely responsible for this increase as a result of their policies to "deinstitutionalize" state supported mental institutions and to place these individuals in ICF-MRs and nursing homes funded by Medicaid.

Studies have indicated that growth of nursing home expenditures are also due primarily to increased utilization and general inflation. Nursing home services are one of the few services covered by Medicaid which can attest to the increased utilization as having a significant impact on the growth of expenditures. The elderly population in need of these services has been increasing and is projected to expand in future years.

AHCA maintains that Medicaid nursing home care is very cost effective. It should be noted that states have successfully employed prospective reimbursement systems for nursing homes for several years in order to contain costs. Medicaid reimbursement to nursing homes is unique in that historically states have a considerable amount of flexibility and latitude in developing payment methodologies for nursing home services. Since the inception of the program, states have had the great flexibility to develop efficient nursing home reimbursement methodologies.

As a result of this flexibility, in 1977 states began developing and implementing prospective reimbursement systems with built-in cost containment mechanisms and incentives, such as cost center limits and ceilings on payment rates. Currently, thirty-eight states employ prospective reimbursement; forty-eight states establish various ceilings on costs; twenty-four states impose overall rate limits; thirty-three states have cost center ceilings; and thirty-four states offer incentives for efficient providers.

These systems have been successfully employed to contain nursing homes' costs and typically result in payments to providers that are lower than their costs of serving needy Medicaid patients. As a result of these systems with their cost containment mechanisms, payments to nursing homes have been restrained. It should also be noted that a recent amendment to the Medicaid law provides states additional flexibility and latitude in establishing prospective reimbursement systems and determining payments to nursing homes.

Medicaid nursing home cost increases have been limited to increases attributable to inflation, greater utilization and costly state regulations. These costs have grown approximately 15 percent per year in recent years largely because of inflation. The NGA maintains, however, that the state governments could convert a block grant for the long term care portion of the Medicaid program, capped at 7 percent in fiscal year 1982, into a more comprehensive system of services, including non-institutional care.

To apply a cap and block grant solely on long term care would be to single out one group of beneficiaries to bear the burden of reduced Federal suport which is contrary to the Administration's objective of equitable sacrifice. In addition, to the extent that nursing home services are not provided and non-institutional services are not available, recipients will be forced to remain in more costly hospitals which will increase expenditures in that area.

[Attachment A]

Implications of the Budget Reductions on Long-Term Care Programs

Needs of Beneficiaries

AHCA believes that it would be tragic for the Federal government to abrogate or to transfer to the states its responsibility for the long term health care needs of Medicaid recipients as part of a Federal budget reduction, without developing adequate assurances that these individuals will receive the services they need.

Nursing homes are the principal institutions for delivery of long term care for the elderly and handicapped. Home health and support services are an alternative to institutional care but these programs are haphazardly funded by the Federal government and are unavailable in many parts of the country. Medicaid and to a much lesser degree, Medicare, are the principal Federal funding mechanisms for care inside a nursing home. Federal support of home health and support services is less extensive and less concentrated, involving Titles XVIII, XIX and XX.

We advocate the development in the community of a mix of facility and home based services that will permit delivery of care in the most appropriate setting. We are concerned, however, that some states will leap into lower cost home health programs and withdraw funding for care in long term care facilities to the detriment of Medicaid recipients of institutional care, if Federal funds are cut back and states are given discretion to do so. Perhaps 10% of all residents in nursing homes could be cared for in a community based setting if appropriate services were available. Many residents in nursing homes, particularly those covered by Medicaid do not have homes or living relations that would permit them to take advantage of home health care programs. An increasing number of residents supported by Medicaid are the "frail elderly" who are severely debilitated and could not function outside an institutional setting, except through massive expenditures for care.

The Federal government established the patterns of long term care delivery by its categorical requirements in both Title XVIII and XIX. If the patterns of delivery are to be restructured, the states must be given maximum flexibility to assess needs and package delivery systems, but the Federal government has a responsibility to insure that current recipients are not disenfranchised and that long term care services are available to entitlement recipients who need them.

Requirements of Providers

Both the Federal and state governments have a stake in maintaining the viability of health care providers when they cut back on Medicaid funding. Hospitals, physicians, nursing homes, home health agencies—all provide necessary services to the community.

Modern nursing homes are largely the product of a public demand, generated by the creation of Title XVIII and Title XIX. Nearly 50 percent of all long term care facility residents are funded by Medicaid. Another 4 percent are funded by Medicare. Nursing home construction, life and fire safety devices, staffing, and administration are mandated by Federal or supplementary state regulations.

Unlike hospitals, nursing homes are primarily (80 percent) for-profit corporations. They are labor intensive businesses with a median size of 100 beds and employing over one hundred staff members as an average. General inflation and Federally mandated requirements such as minimum wage increases and compliance with life safety codes have greatly increased the cost of maintaining a nursing home.

Despite the increases in expenses, the cost of nursing home services (i.e. nursing care, social programs, room and board) have been held to a reasonable level in recent years. The expansion of nursing home costs in the Medicaid program is a result of increased utilization resulting from a growth of the elderly population needing long term care, eligibility criteria adopted by the states and a shift of expenditures for the care of the mentally ill and retarded from state programs to Medicaid, as well as the proliferation of excessive government regulations unrelated to patient care. Despite these increases, most state Medicaid plans have stringent controls on the per-patient charges for Medicaid nursing home services through the use of prospective reimbursement methods with built-in cost containment features, plus incentives for efficiency. A provision in the recently enacted 1980 Omnibus Reconciliation Act (Public Law 96-499) was specifically designed to increase state flexibility for developing cost-effective Medicaid nursing home rates.

Drastic reduction in Medicaid reimbursement to nursing homes will have the effect of lowering the quality of care or restricting bed availability for Medicaid patients, unless the administrative and regulatory requirements required by the Federal government are simplified and streamlined. Providers can furnish care at lower costs if they are given freedom, within reasonable limits, to produce cost savings. Expansion of prospective systems to all state Medicaid programs would further reduce program costs, particularly if providers are permitted to keep part of the cost savings as an incentive for efficiency.

THE MEDICARE-MEDICAID CONNECTION

The Reagan Administration has targeted Medicaid for reduction of Federal outlays, but has exempted Medicare as part of the social safety net. Federal Medicare outlays are projected at over $40 billion in fiscal year 1982; Medicaid outlays at $18.2 billion. AHCA agrees that Medicare benefits are an essential component of the well-being of our senior citizens. We also point out that Medicaid coverage for long term care services, particularly for those recipients without families or other means of support, is an equally valuable component of the social safety net.

AHCA does not believe that current Medicare reimbursement or regulatory policies are efficient vehicles for the delivery of care to benficiaries needing acute or long term care. Medicare's retrospective "reasonable-cost" reimbursement policies are inflationary and do not impose either incentives or disincentives for cost-effective delivery of care.

Title XVIII policies have had a pernicious effect on long term care. Nursing home operations have dropped out of Medicare in droves because of excessive administrative requirements, low utilization created by arbitrary Federal policy, and retrospective denial of reimbursement. Medicare policies have also had a harmful effect on the Medicaid program. Several states have adopted Medicare principles of reimbursement with little opportunities for cost savings by the government other than ruthless denial of charges for service rendered and concomitant provider uncertainty and resentment.

AHCA implores the Administration and the Congress not to uncritically reject Medicaid and endorse Medicare. Medicaid long term care reimbursement and regulatory policies are more cost-effective than their Medicare counter-parts. Adoption of the former for all institutional providers participating in either Title XVIII or XIX programs would drastically reduce Federal health care expenditures without affecting benefits for recipients.

[Attachment B]

SPECIFIC BUDGET REDUCTION RECOMMENDATIONS

DEVELOPMENT OF COST EFFECTIVE PROVIDER REIMBURSEMENT POLICIES

AHCA believes that the recent changes in nursing home reimbursement effected by Public Law 96-499 can serve as a model for removal of impediments for states to develop cost effective reimbursement methodologies. Section 962 of Public Law 96-

499 often referred to as the "Boren Amendment," provides that states must reimburse nursing homes based on rates that are adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in accordance with mandated requirements and standards. Within this broad statutory requirement, states have the flexibility to develop their own methodology for establishing rates based on the unique needs within and characteristics of the state. In fact, the principle purpose of the amendment was to provide states additional flexibility in determining reimbursement to nursing homes.

Although states have been given considerable flexibility and latitude, the amendment also requires that states provide assurances to the federal government that the rates are adequate and satisfy the statutory requirement. Thus, the states have obtained sufficient flexibility while the federal government has retained appropriate authority to ensure that its minimum requirements are met. This approach to reimbursement for nursing homes could serve as a model for other providers and other aspects of the program as well as fitting within the overall framework of the Medicaid program AHCA recommends—retain Medicaid as an entitlement program but permit maximum state flexibility in determining eligibility, services, and reimbursement.

Medicaid reimbursement to nursing homes is unique in that even prior to the additional flexibility provided by the "Boren Amendment," states had a considerable amount of flexibility in developing reimbursement methodologies for nursing homes. For several years states have used this flexibility to control the per patient day costs of nursing home services through the employment of prospective reimbursement plans with built in cost containment mechanisms, such as cost center limits and ceilings on payment rates. AHCA earnestly believes that as a result of these systems with their cost containment mechanisms and the unrealistically low reimbursement rates which preceded these systems, payments to nursing homes are not excessive and contain "very little fat" controllable by a facility. To assume that payment rates to nursing homes could be significantly reduced without having a detrimental impact on quality of care would be a tragic mistake.

CURTAILMENT OF FREEDOM OF CHOICE

Under the existing freedom of choice statutory provision and implementing regulations, the only services which are amenable to volume purchasing are eyeglasses, hearing aids, prescribed drugs and durable medical equipment. Last year, a provision was introduced (and subsequently dropped) in the omnibus reconciliation bill limiting freedom of choice for beneficiaries obtaining services and supplies under Medicaid. The intent of this provision was to enable states to achieve greater savings through bulk purchase of services. The states were to be limited in this only to the extent that the restrictions on freedom of choice were cost-effective, assured reasonable access to services, and avoided substantially adverse effect on access to teaching hospitals.

AHCA supports curtailment of freedom of choice to permit state governments the opportunity to negotiate competitive prices for provider services and vendor goods, provided there are safeguards to prevent the use of this provision to exclude participation by providers or vendors for any other reason than non-competitive prices.

GREATER STATE COST SAVINGS FLEXIBILITY

Federal laws should be amended to permit states to develop innovative cost savings program.

Several states have sought authority to introduce costs savings measures in the Medicaid program. Last year the Alabama Congressional delegation introduced legislation permitting family supplementation, copayments and greater authority to crack-down on program abusers. Massachusetts is currently exploring a negotiated rate purchase system with groups of providers.

The Administration has promised to develop a comprehensive health care reform package which would reduce the growth of health care costs. While work on that initiative goes on, states should be permitted maximum flexibility to develop cost-effective systems by the elimination of Federal legislative and regulatory restrictions.

RESTRICTING ELIGIBILITY

One approach to reducing Medicaid expenditures is to address the issue of increasing utilization by imposing stricter limits on eligibility for benefits. Eligibility could be tightended up in an effort to ensure that only the "truly needy" are receiving benefits.

For example, the income standard to qualify as a "medically needy" recipient could be reduced. The medically needy are generally people whose incomes are too high to receive cash assistance (e.g., SSI, AFDC) but who cannot afford to pay their medical bills. The amount of their incurred medical expenses must equal or exceed the amount of income they have above the state income level. Each state with a medically needy program (over half the states) sets income levels for determining eligibility of the medically needy. The level at which these income standards are set could be reduced so that only the "truly needy" are covered.

Another approach, which has been proposed by the Congressional Budget Office, is to eliminate from coverage as "categorically needy" individuals who only receive optional state supplements. The categorically needy are generally individuals who are eligible for Medicaid because they can meet the income requirements for cash assistance, regardless of the extent of their medical bills. However, thirty-four states also have elected to include in the categorically needy group persons whose income disqualifies them for federal SSI payments but who receive state supplements. That is, these individuals do not receive federal cash assistance, but receive state supplements and are entitled to Medicaid benefits as the categorically needy group. The Congressional Budget Office has estimated that a savings of $320 million could be realized in the first year if these individuals no longer receive Medicaid benefits as categorically needy. The five year savings was estimated to be almost $2 billion. It was further estimated that elimination of this coverage would eliminate or reduce Medicaid benefits for about 600,000 persons. However, the "truly needy" would continue to receive benefits because those individuals living in states with coverage for the medically needy could continue to receive benefits if they had sufficient medical expenses.

SURVEY AND CERTIFICATION REFORM

A poll of AHCA members last year revealed that long term care facilities are surveyed an average of ten times each year. Each survey involved approximately three government inspectors and takes the full time of three to five facility staff members. We believe that the survey process is an expensive administrative process.

Immediate changes could save program administration costs, free facility staff for patient care activities, and reduce expenditures for unneeded correction plans. Such changes include:

Combining all the federally mandated surveys into one. We see no reason why an inspection of care team, certification team, Professional Standards Review Organization team and Health Planning team (for appropriateness review) all must review essentially the same components of long term care facilities.

Extend provider agreements. Facilities performing well could be reviewed every two years rather than annually if provider agreements could be made for twenty-four months. This way, survey teams could concentrate their efforts of facilities having numerous deficiencies.

Revise the survey report form. Currently, inspectors survey five hundred twenty separate items in skilled nursing facilities. We suggest that this form be cut back to only statutorily required and other elements critical to the provision of health care.

Improve survey training so that all inspectors know the standards and can recommend cost effective corrections. Misinterpretation and surveyor private interpretation of rules account for large expenditures, eventually billed to the Medicaid program. One AHCA facility replaced five doors five times because each successive inspector had a different idea of fire door requirements.

REVISE REGULATIONS AND ELIMINATE THOSE WHICH ARE NOT COST EFFECTIVE OR DO NOT RELATE TO PATIENT CARE

The skilled and intermediate care facility conditions of participation contain numerous provisions that are either not cost effective and/or not related to patient care. These rules relate to committee meetings, recordkeeping requirements and other activities. The interpretive guidelines accompanying the nursing home standards frequently impose additional requirements. For example, regulations requiring "timely visits" by consultants are translated in the guidelines to five hours per week. We suggest that the conditions of participation and guidelines be reviewed and rewritten in an outcome oriented, rather than process oriented fashion. This regulation reform would result in more efficient use of nursing home staff.

Some examples of rules we believe should be reviewed include:

Frequency of physician visit—Regulations mandate that physicians must visit patients every 30 or 60 days, whether or not the patients' conditions warrant a physician visit. We suggest rules be revised to require visits based on patient need, an allowance of nurse practitioner and physician assistance visits (under general

physician supervision) in lieu of physician visits. This change would reduce physician Medicaid costs, not facility costs.

Committees: The pharmaceutical, infection control and utilization review committees, each necessitating numerous professional's attendance, could be eliminated if their functions could be accomplished more efficiently.

Consultants: Highly qualified consultants are required in skilled facilities whether or not department performance shows a need for consultants. These include: medical records administrators, social workers, dieticians, advisory dentists, activity consultants.

Patients' rights—Interpretive guidelines far exceed the regulations. For example, guidelines require that patients who are wearing safety devices be observed every 30 minutes and that observation must be documented.

Since federal nursing home rules apply to facilities with both Medicare and Medicaid patients, the potential savings realized would apply to both the Medicare and Medicaid programs. We believe that these measures would effectively control the growth of long term health care costs (but not necessarily lead to immediate cost savings).

A second step-in regulation reform must be directed at the state level. The federal government portion of Medicaid payment must cover state as well as federal rules. These state standards often far exceed federal rules, especially in the areas of staff qualification, numbers of staff, and reporting requirements.

Two approaches could be directed at curbing the growth of health care costs as a result of state rules:

Disallow costs related to state requirements from the federal Medicaid match. In this option, the federal government would not pay for state imposed standards beyond federal requirements.

If federal payment for state standards is continued, require states, as a condition of being part of the Medicaid program, to establish mechanisms to review the cost and necessity of their rules. These mechanisms could be similar to those mandated on the federal level by Executive Order 12291, (regulation reform), the Regulatory Flexibility Act (for small entities), and the Paperwork Reduction Act.

SIMPLIFIED UTILIZATION REVIEW

Utilization review in long term care facilities, the system of assuring that each Medicare and Medicaid patient needs the services being given, is an expensive and burdensome Medicaid requirement. We believe it is not worth the Medicaid dollars now spent. Typically, it involves three activities: (1) Each attending physician must visit Medicaid patients either monthly or bimonthly in order to certify the need for continued care; (2) Facilities hold monthly meetings with administrative and nursing staff and three private physicians in attendance to review physician certification and continued need for care; (3) At least annually, an inspection of care team visits each facility to inspect the record of each public pay patient. (These visits often involve several weeks of daily facility attendance with three or more health professionals. This survey is paid in full by the Federal government.)

This process could be greatly simplified and made less costly to the Medicaid program if:

Greater attention was given to patients entering the long term care system and less attention to those already placed in facilities. A good assessment prior to admission could reduce unnecessary placements.

Patients with little discharge potential were reviewed less frequently than is now required. If discharge is not expected for at least six months, review should not be necessary for six months.

Patients with no discharge potential were not reviewed. In some instances, especially in the case of terminally or progressively ill, utilization review is only a paper exercise.

Mail, telephone and other expedient review procedures replaced physician visits, meetings, and on-site review. The Iowa Professional Standards Review Organization has found these procedures to be extremely cost efficient.

Physicians assistants and nurse practitioners (as well as physicians) could certify the need for care.

Combine the three review activities into a single, binding review process.

CONSIDER SHIFTING PLACEMENT OF PATIENTS FROM MORE COSTLY TO LESS COSTLY HEALTH CARE SETTING

Nursing home Medicaid expenditures must not be viewed in a vacuum. The provision of long term care is actually performed along a continuum, in various locations—from services rendered in the home to services provided in acute care

hospitals. These services may be paid for by the Medicaid program, by state funds, through the Veterans Administration, by Medicare, or by other federal programs. We believe that services should be delivered in the most cost effective setting that meets the patient's needs. We suggest that funds expended through Medicaid be viewed in relation to the overall government dollars spent in providing long term care. Reduction of Medicaid nursing home disbursements will have the effect of raising Federal long term care costs in other programs, usually at a higher level of expenditure.

The community long term care facility is the most cost-effective source of health care for individuals in need of the services provided in these facilities. We wish to bring to your attention:

When the Veterans Administration places a veteran in a community nursing home, the cost of that care is less than over half of what it would cost in a long term care Veterans Administration facility. Still, the VA is planning on converting or building thirty-two nursing home facilities in the near future.

State mental institutions cost two to four times as much to care for a patient as would a community long term care facility. Some chronically mentally ill patients currently in state institutions could be adequately cared for in general community nursing homes. Others could be cared for if community long term care facilities were permitted to specialize in the care of the chronically mentally ill. However, present law excluded Medicaid reimbursement for certain age groups when such specialization exists.

Likewise state institutions for the mentally retarded are far more costly than most long term care facilities. Current rules require that facilities for the mentally retarded all have similar program standards, whether or not all patients could benefit from such programs. If program requirements were based on the patient needs and potential rather than blanket standards, cost savings would be realized.

Some hospitals are gradually becoming long term care facilities because community nursing home placement for patients is not available. Large numbers of patients are receiving acute care (at acute care prices) when they need long term care (at approximately a quarter of the cost). During 1980, the American Association of Professional Standard Review Organizations conducted a one day survey of patients awaiting nursing home placement. The 101 PSROs reported a total of 17,783 patients awaiting placement on one single day. A reason for this "back-up" is resistance of long term care providers to participate in the Medicare program because of numerous problems inherent in this program.

We believe that the hospital back-up problem will continue and that its toll on Medicare and Medicaid programs will escalate. A reason is that many states are trying to control (or cap) their long term care expenditures by prohibiting the building of long term care facilities and the addition of beds. We see this as a short-sighted solution to a complex problem.

Statement by Dr. Thomas G. Bell, Executive Vice President, American Health Care Association

Mr. Chairman, members of the committee, I am grateful for the opportunity to communicate to you the position of the nearly 7,500 members of the American Health Care Association on the President's budget proposals and to examine their impact on older Americans. I will confine my remarks to the administration's medicaid proposals.

The American Health Care Association today offers specific suggestions to help the administration and Congress restore the viability of the American economy by reducing the growth of the Federal budget. We recommend adoption of several statutory and regulatory amendments to give State governments sufficient flexibility and incentive to achieve substantial savings in the medicaid program without curtailing basic entitlements or services for those who need them:

1. Provide the States with authority to develop cost-effective reimbursement policies for all providers similar to the recent changes in nursing home reimbursement effected by Public Law 96–499.
2. Permit States to achieve greater program savings in purchase of health care services and medical equipment by amending present law.
3. Encourage the States to reasonably restrict "medically needy" eligibility by withholding Federal payments for higher income recipients.
4. Amend Federal laws to permit States to develop innovative cost savings programs such as co-payments and family supplementation.

We also recommend the following initatives for achieving greater cost savings and efficiency in the long term care component of medicaid:

1. Redesign federally mandated survey and certification procedures for maximum efficiency.

2. Revise regulations and eliminate those that are not cost effective or do not relate to patient care.
3. Simplify utilization review.
4. Develop programs to place patients in the least costly setting that meets their health care needs.

We understand that the Department of Health and Human Services has chosen not to seek similar legislative and regulatory relief for State governments seeking to implement cost savings initiatives in the medicaid program but has opted to provide broad waivers to the States instead. We believe that this is a mistake because it will permit the Department to exert bureaucratic controls over state initiatives and would exclude the Congress from a role in determining which aspects of the program are to be eliminated and which are to be retained in the interests of efficiency.

I would also like to comment on the alternative health care budget savings proposals developed by the National Governors' Association. AHCA endorses the National Governors' Association's call for reform of medicare reimbursement. We agree with the Governors that the current reimbursement method is inflationary and inefficient. We maintain that the Federal Government could significantly reduce the growth of the Federal budget and nationwide health care costs by implementation of a well-designed prospective reimbursement system for all services funded by title XVIII. The American Health Care Association is currently conducting a study of the potential impact of prospective reimbursement on skilled nursing facilities participating in medicare. We believe that it will expand skilled nursing services, limit the need for patients to remain in a costly hospital bed because a bed in a skilled nursing facility is not available, and reduce the cost of the individual's care and overall expense of the medicare program.

AHCA opposes the National Governors' Association's second alternative to the Administration's proposal to cut medicaid funding—that is the NGA's recommendation to cap Federal Medicaid expenditures for long term care services. AHCA maintains that to single out long term care as the only vehicle for achieving savings in the medicaid program would be inequitable, would not achieve the savings sought by the administration, and would inflict undue hardships on nursing home residents. Medicaid nursing home services in most States are extremely cost effective thanks to the use of reimbursement methods with built-in cost containment features. The growth of long term care costs in the various State medicaid programs have resulted almost exclusively from inflation or from increased utilization induced by State policies.

In particular, the States have shifted the responsibility for the mentally ill and mentally retarded from State-run institutions outside the medicaid program to intermediate care facilities for the mentally retarded and nursing homes that are funded by medicaid.

Were it not for this shift, 31 States would show a decrease in the proportion of medicaid in their budgets in fiscal year 1982 over fiscal year 1978. Instead, only 19 States will show such a decline. This is what is expanding medicaid costs: not normal nursing home services provided to all title XIX recipients, but the distortion created by State decisions to transfer part of their health care responsibilities to Federal expense.

Your consideration of these proposals not only will directly affect more than three-quarters of a million nursing home residents presently on public support. Your consideration not only will affect the Nation's 18,000 medicaid and medicare nursing homes, almost half of which are our members, and the million constituents who work in them. Your consideration will impact most significantly on the millions approaching 65 who will need and who deserve quality long term care.

Senator HEINZ. Our last witness today is David Gagnon.
Please proceed, Mr. Gagnon.

STATEMENT OF DAVID E. GAGNON, M.P.H., WOMEN AND INFANTS HOSPITAL OF RHODE ISLAND, PROVIDENCE, R.I.; PRESIDENT, NATIONAL PERINATAL ASSOCIATION

Mr. GAGNON. Senator Heinz, I would like to introduce myself. I am president of the National Perinatal Association, which is a multidiscipline organization of physicians, nurses, allied help personnel and consumers who are dedicated to the advancement of perinatal care in the Nation.

We represent more than 5,000 members nationally. I am also vice president of Womens and Infants Hospital of Rhode Island.

I would like to summarize briefly my thoughts that were submitted by written statement, and these overlap both in title V and title XIX and, therefore, I would like to submit this as testimony, both for today's hearing and tomorrow's.

Senator HEINZ. Without objection.

[The testimony to be included in April 1, 1980, testimony.]

Mr. GAGNON. Thank you.

The National Perinatal Association believes that all pregnant women have a right to a basic level of obstetric care during the prenatal period, and that through a coordinated system of health care incorporating the private, as well as public sectors, advanced facilities should be available to mothers at high risk, who are poor, throughout the pregnancy.

The reason for this commitment derives from accumulated experience and the increasing evidence in the national and international literature which clearly shows that mothers' receipt of health services during pregnancy is associated with survival and the quality of life of her infant.

Historically, there has been support in this Nation for policies and programs related to maternal and child health and it has been and remains rooted in basic human decency and the collective social conscience of the Nation.

Indeed, the first Federal grants and the first office for maternal and child health was created in 1912 and later supplemented by the Sheppard Towner Act of 1921, which programs laid the foundation for those later authorized under title V of the Social Security Amendments of 1935 for maternal and child health and crippled children services.

More recently, the title XVIII amendments passed in 1965 supplemented these.

We believe that children matter for themselves and that families are due the assistance that will enable them to sustain their integrity.

On this account alone, we consider it necessary that programs for mother and children remain a distinct and visible entity. Nevertheless, it is important to remember that many economic benefits flow to the general well-being of the Nation from enlightened public policies and programs designed to promote sound maternal and child health. Not least among these are the reductions and the need for long-term institutionalization and other costly rehabilitative and maintenance services, as well as the economic returns from adults whose health and vigor were spared from serious problems through these programs.

The effects of resources allocated to maternal and child health programs, particularly those funded under title V of the Social Security Act, are among the very few human and health services that can be measured in real and quantitative terms. In effect, these programs have been, and remain, testimony to how a few well-placed Federal dollars can be the trigger to creation of State and local health service delivery systems, which incorporate the best this country had to offer in professional expertise.

The effect and absence of this prenatal care is dramatically demonstrated by an occurrence rate of 22 percent low birth weight infants born to the approximately 60,000 mothers in the United States who had no prenatal care in 1977.

The estimated cost of neonatal care care for these infants was $90 million, to which must be added the untold billions that will be spent on continuing care for long-term sequela.

To this end, in the creation of a medicaid cap, we believe that we must exempt those young women who are presently in need of medicaid coverage in those 33 States in which it is either optional or not now present for their first pregnancy.

We also believe that title V should remain unchanged in the States, and under the purview of this committee so as an authority similar to the authority that was created by title V can continue in existence to serve all pregnant women, including those under medicaid.

A title V maternal and child health administration should continue to care for the medically indigent and plan for all maternal and child health programs in partnership with the States.

We believe that these services are so critical to the well-being of mothers and infants that they should remain substantially the same as now constituted.

Senator CHAFEE. Well, thank you very much, Mr. Gagnon. I came down particularly to hear you and I am sorry that I missed the first part.

We appreciate what you had to say here, particularly—well, the thrust of your argument which is against block granting title V.

Well, you have come to the right place because this falls under the jurisdiction of this committee and we will be wrestling with those matters in the days ahead.

Thank you very much.

As I understand, you are the final witness.

I want to thank you for coming today.

[Statement follows:]

TESTIMONY OF THE NATIONAL PERINATAL ASSOCIATION BY DAVID E. GAGNON, M.P.H., PRESIDENT

SUMMARY

The NPA believes that elimination of a designated federal-state authority as embodied in Title V will endanger the progress that has been made in improving care for mothers and children.

The NPA recommends that Title V be preserved as presently constituted under the control of this Committee.

The NPA recommends creation of a National maternal and child health administration in HHS.

The NPA recommends that those categorical programs related to Title V be clustered and administered by the designated MCH agency in each state.

The foundation for child and maternal health care programs go back to the first three decades of this century with the creation of a Children's Bureau in 1912 and the promulgation of the Sheppard Towner Act in 1922. These entities created by Republican administrations were committed to a national program to improve maternal and child health. The infrastructure of the Children's Bureau became the designated agency for the administration of that money granted by Title V of the Social Security Act of 1935. The organization of a governmental agency dedicated to maternal and child health is now emulated in most countries of the world.

The reason for the creation of such an organization remains as relevant today as it was in 1935. In 1935 120,000 infants did not survive their first year for a rate of 58/1000 live births. Of some 3.3 million infants born annually in the United States,

approximately 500,000 are considered to be at risk. In this cohort, it can be expected that 50,000 infants will die and another 250,000 infants will be born with congenital anomalies. Additionally, 33,000 fetal deaths occur before or at birth. We have come a long way since 1935, but we still have a way to go.

Many believe that our country should reduce its infant mortality to 9/1,000 live births by the end of this decade. It is now at 12.8/1,000 live births. If we are to reduce infant mortality, we must concentrate on reducing low birthweight rates in all the states and within each state in those areas that experience the highest rate for low birthweight infants. These infants represent 7.2 percent of all live births in the USA as compared to approximately 3 percent in the United Kingdom and several other European countries. The effect of the absence of prenatal care is dramatically demonstrated by an occurrence rate of 22 percent of low birth weight infants born to the approximately 60,000 mothers in the United States in 1977 who had no prenatal care.

The estimated cost for neonatal care for these infants was $90 million. To this would be added the enormous cost for the long term care of these damaged infants. The cost for adequate prenatal care for mothers is one of the most cost-effective ways to reduce this toll. But to achieve this national commitment to improve care requires a partnership between the federal and state governments. This partnership has been effective for forty-five years as embodied in the Title V legislation. The relatively small amounts of money committed to the designated maternal and child health agency in each state have had an enormous impact on reducing infant mortality and sickness. These agencies not only provide direct services for mothers and children in their states, they have acted as the planning and evaluation arm of the state health departments in developing programs for the coordinated care of all mother, infants and children in their state. Let us not forget the impact they have had on coordinating immunization and other health programs and in regionalizing perinatal and genetics programs. The maternal and child health decisions of health departments have also acted as advocates for services that would improve the care of mothers and children in their states.

The administration's proposal to cluster categorical programs, including Title V, into four generic block grants, our organization believes will endanger the progress our nation has made in reducing maternal and infant mortality and morbidity. We believe that it will not only reduce significantly that money which is now committed for essential direct services as prenatal care but it will also destroy the key advocates for maternal and child health in every state the division so designated in each of the state and territorial health departments. With the elimination of these designated organizations will go much of the effective planning that has gone on over the years and, more importantly, the evaluative base which has monitored the process of health care for mothers and children. Our organization acknowledges that there have been deficiencies in the organization of these programs as indicated in the report "Better Health for Our Children: A National Strategy." We do not believe, however, that these deficiencies merit the drastic step of destroying an organization that has had such an impact on maternal and child health over the past several generations. Elimination of Title V as presently constituted would leave our nation as one of the few in the world without a national directing force to improve the care of mothers, infants and children.

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We strongly recommend that the Title V SSA, MCH and CC programs that are under the jurisdiction of this Committee retain their present statutory authority and remain under the control of the Committee.

We further recommend the creation of a maternal and child health administration in the Department of Health and Human Services with sufficient stature to develop a national strategy for maternal and child health through cooperative planning with the designated agency in each state.

We also recommend that this Committee in cooperation with the Senate Committee on Labor and Human Resources would attempt to cluster those programs that are now administered for the most part in each state by the respective division of maternal and child health in each health department. This block grant for maternal and child health should be designated to go to the appropriate agency in each state for central administration according to the plans developed to improve health care for mothers and children.

It is our belief that with the core Title V money committed to each state complemented by money from a maternal and child health block grant that the essentials of a planned MCH national strategy could be substantially preserved even in light of the severe cutbacks contemplated.

We very much urge your Committee to adhere to the substance of our recommendations. Myself and my association stand ready to work with you and with other concerned parties to develop a plan that will attempt to minimize the jeopardy in which we see mothers, infants and children placed if the concept of block grants as proposed by the Administration is implemented.

NINTH ANNUAL FISCAL PRESSURES SURVEY

1979

**HOSPITAL ASSOCIATION
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MARCH 1981

FOREWORD

The Association's Ninth Annual Fiscal Pressures Survey represents the most dismal financial outlook to date for New York's hospital system. The voluntary and public hospitals of the State have incurred losses exceeding $1 billion since 1974. At the same time, this continuous record of operating losses without major public calamity has dulled the sensitivity of State officials and elected representatives to administrators' and trustees' often-stated concerns for the future well-being of the hospital system.

To some degree, the size, support and momentum of a public service organization, such as a hospital, enables it to avoid backruptcy – despite mounting losses and bad credit ratings – for a significant period of time. However, in addition to relying on good will, what have hospitals done to survive?

- Hospitals borrow money. This increases the cost of health care because interest costs will be calculated into future hospital rates.
- Hospitals have significantly extended the time in which they normally pay their bills.
- Hospitals utilize philanthropic funds to reduce operating losses and pay expenses.
- Hospitals spend depreciation reserves, normally set aside for replacement of plant and capital equipment in order to pay short-term debt.
- Numerous cutbacks are made in areas which do not directly involve patient care, such as delaying purchases, reducing manpower, delaying routine maintenance, as well as eliminating patient amenities.
- Many facilities are beginning to develop contingency plans or actually implement a reduction in services for their communities.
- Some critically needed hospitals have received emergency State and federal bail out funding. Also, emergency appeals and "reimbursement experiments" have begun in order to avoid additional losses inherent in the current system.

In spite of these stop-gap efforts and outstanding management initiatives, hospitals do go bankrupt and hospitals do close. During the past five years, 47 New York State hospitals closed as a result of financial problems. These closures, combined with decertifications and transfers of acute care beds to long term care, have resulted in a reduction in the State hospital system capacity of over 10,000 beds.

Although the hospitals in New York State have fallen into a situation where their financial position and credit worthiness are the worst in the nation, the most difficult test of their resourcefulness may come. Governor Carey has proposed a series of reductions in Medicaid expenditures for Fiscal Year 1981-82 amounting to $43.1 million. These reductions in State expenditures will trigger additional losses of $46.1 million in federal funding and $43.1 million in county support, resulting in a total reduction of $132.3 million. Compounding the cutbacks on the State level, President Reagan is proposing a $100 million reduction in federal Medicaid spending for the current Fiscal Year and a $1 billion reduction in Fiscal Year 1982 by placing a 5% cap on program growth. Governor Carey estimates the loss to New York State at $300 million.

These federal and State curtailments in the Medicaid program will have a deleterious impact on Blue Cross reimbursement, which by government edict, is tied to the Title XIX program. Further, should the State proposal for takeover of the Medicare program succeed, the adverse financial plight of the hospitals will intensify for it also would be linked to Medicaid reimbursement.

The fiscal viability of the hospital system in the Empire State has reached the crisis point. Those committed to its survival -- government officials to private citizens – must meet the challenge. It is hoped the statistics in this Survey will underscore this situation.

George B. Allen
President

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INTRODUCTION

The Hospital Association of New York State (HANYS) has been analyzing the profits and losses reported by member hospitals in their annual audited Financial Reports since its 1971 survey. Financial Reports refers to Uniform Financial Reports for the years 1975 through 1978 and to the Institutional Cost Report and the Blue Cross and New York State Supplement to the Institutional Cost Report for 1979. This ninth annual survey compares data for the five years 1975 through 1979.

This survey includes the reports of 220 voluntary and 25 public not-for-profit hospitals. Every reasonable effort has been made to include every member hospital. The only hospitals not included are those for whom data was not available to permit a five-year comparison.

Because of accounting and reporting changes, data for the New York City Health and Hospitals Corporation (NYCHHC) facilities could not be included with the information of the 25 public hospitals referred to above. Nevertheless, data for the NYCHHC are separately reported in the vital signs section.

Amounts from the financial reports of voluntary hospitals and from public hospitals have been separately analyzed to avoid the possibility that government subsidy programs and/or policies might have yielded misleading or noncomparable results. In fact, where included and identified on public hospital financial reports, subsidies have been subtracted from total revenues in compiling this study.

SECTION I
VOLUNTARY AND PUBLIC HOSPITAL

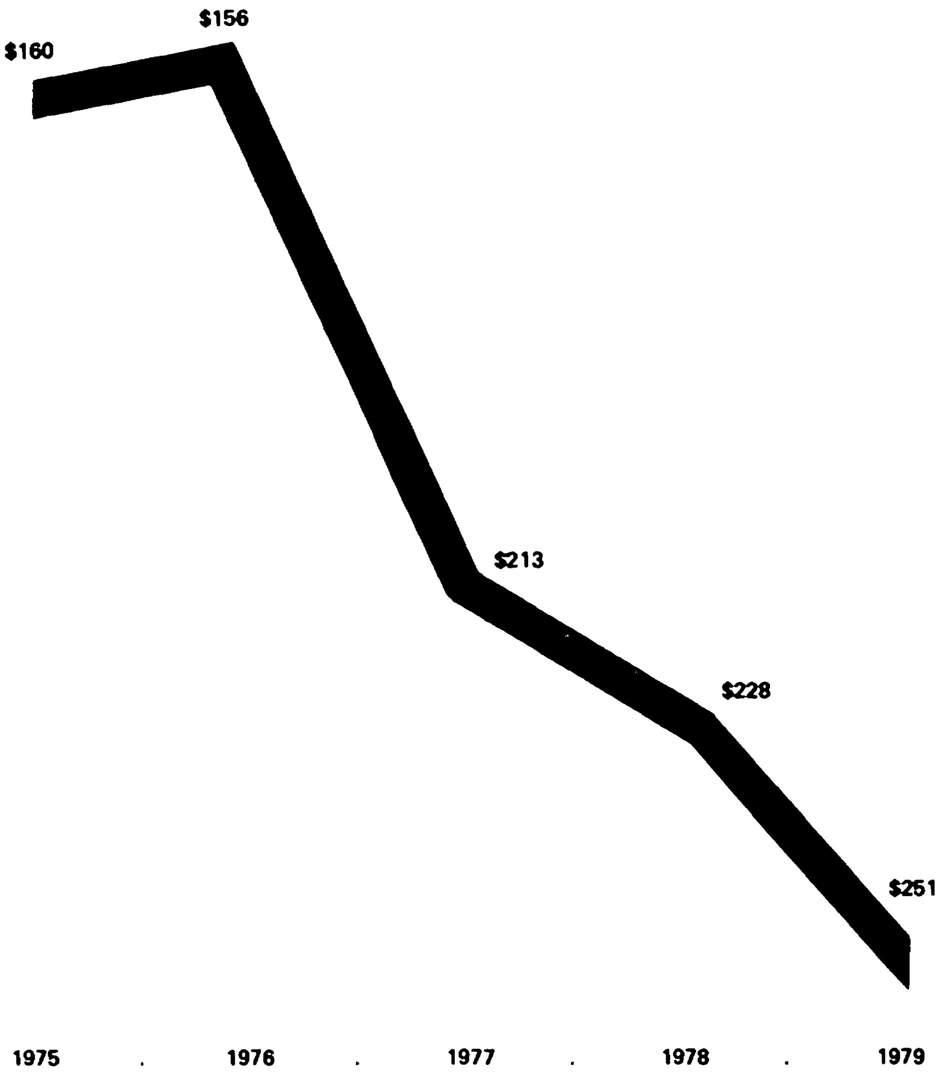
HIGHLIGHTS

- 79.6% of New York's voluntary and public hospitals operated in the red in 1979.
- Average voluntary and public hospital net operating losses increased 3.4% from $1.324 million in 1978 to $1.369 million in 1979.
- Aggregate voluntary and public hospital net operating losses increased over 10.1% from $228 million in 1978 to $251 million in 1979.
- 110 voluntary and public hospitals operated in the red each year from 1975 through 1979 rolling up an aggregate $919 million loss - an average of almost $1.7 million per hospital each year.
- Total "bottom line" losses rose 9.8% from $183 million in 1978 to $201 million in 1979 for voluntary and public hospitals.
- Non operating revenues (including contributions, bequests, other philanthropy, and income on endowments) of voluntary and public hospitals fell steadily from 2.0% of expenses in 1975 to 1.6% in 1979.
- Only 8 hospitals had no losses in any of the 5 years from 1975 to 1979.

245 VOLUNTARY AND PUBLIC HOSPITALS
NET OPERATING LOSS TREND

	AGGREGATE NET OPERATING LOSSES	HOSPITALS WITH NET OPERATING LOSSES		HOSPITALS WITH NET OPERATING PROFITS	
	($ Million)	$ Million	Number	$ Million	Number
1975	$160	$175	167	$15	78
1975 to 1976: Increase/(Decrease)					
Amount	$(4)	$(7)	28	$(3)	(28)
Percent	(3)%	(4)%	17%	(20)%	(36)%
1976	$156	$168	195	$12	50
1976 to 1977: Increase/(Decrease)					
Amount	$57	$62	3	$5	(3)
Percent	37%	37%	2%	42%	(6)%
1977	$213	$230	198	$17	47
1977 to 1978: Increase/(Decrease)					
Amount	$15	$18	(11)	$3	11
Percent	7%	8%	(6)%	18%	23%
1978	$228	$248	187	$20	58
1978 to 1979: Increase/(Decrease)					
Amount	$23	$19	8	$(4)	(8)
Percent	10%	8%	4%	(20)%	(14)%
1979	$251	$267	195	$16	50

**245 VOLUNTARY AND PUBLIC HOSPITALS
NET OPERATING LOSS TREND
($ MILLIONS)**



VOLUNTARY AND PUBLIC HOSPITAL
PROFIT AND LOSS SWINGS
FIVE-YEAR IMPACT
1975 - 1976 - 1977 - 1978 - 1979

				Aggregate Five Year Net Profit or (Loss)	
	Number	Percent	Cumulative Percent	$ Million	Cumulative $ Million
Loss all 5 years	110	45%	45%	$ (919)	$ (919)
Loss 4 of 5 years	61	25	70	(94)	(1,013)
Loss 3 of 5 years	31	13	83	(37)	(1,050)
Loss 2 of 5 years	20	8	91	(2)	(1,052)
Subtotal of Net Losses	222	91	91	(1,052)	
Loss 1 of 5 years	15	6	6	20	(1,032)
Some profits each year	8	3	9	24	(1,008)
Subtotal of Net Profits	23	9	9	44	
Net Losses	245	100%	100%	$(1,008)	

One hundred ten of the two hundred forty-five voluntary and public hospitals studied suffered a loss for each of the five years – 1975 through 1979. Only eight hospitals (3%) were in the black for every one of the five years.

The hospitals which had operating losses in every one of the five years accounted for 45% of the total surveyed. Their aggregate five-year losses were $919 million -- an average of more than $180 million every year.

On the average, each of the one hundred ten hospitals in the red each year lost more than $1.6 million every year from 1975 through 1979. Conversely, the average annual operating profit of each of the eight hospitals in the black was only $ .6 million.

The cumulative impact of these operating results for the five years 1975 through 1979 is illustrated by the accompanying graph.

VOLUNTARY AND PUBLIC HOSPITAL
PROFIT AND LOSS SWINGS
FIVE-YEAR IMPACT
1975 through 1979

VOLUNTARY AND PUBLIC HOSPITAL
NON-OPERATING REVENUE

	$ Million	% of Expense
1975	$81	2.0%
1976	80	1.8
1977	80	1.6
1978*	86	1.6
1979	94	1.6

*NOTE: In 1978, one hospital reported receipt of the proceeds of a trust in excess of $9 million. Due to the extraordinary nature of this transaction and to avoid distortion of the year-to-year comparisons, the amount has been excluded from the $86 million in the table above.

Unrestricted contributions, bequests, and other philanthropy are reported in the special "non-operating revenue" section of the financial reports. Unrestricted income earned on the invested proceeds of such philanthropy plus unrestricted income earned on endowments whose principal has been restricted as to use by the donor are also reported as "non-operating revenue". Both philanthropy and the income earned on unconsumed, invested philanthropy are important sources of revenue needed to defray expenses such as bad debts and free care not reimbursed by Blue Cross, Medicaid, No-Fault, or Workers' Compensation under New York State revenue controls.

EXPENSES

	Expenses ($ Millions)	% of Increase
1975	$4,064	
1976	4,497	11%
1977	4,871	8
1978	5,325	9
1979	5,915	11

New York's hospitals have contained the rate of increase in expenses for 1979 below the general rate of inflation as measured by the Consumer Price Index.

A SECOND BASIS FOR ANALYSIS – "BOTTOM LINE" RESULTS

Profits and losses are analyzed on two bases. The first basis focuses on "operating" results by subtracting total costs from total revenues exclusive of "non-operating revenue", which is reported in a separate section of the financial reports.

The second basis is referred to as "bottom line" results. "Non-operating revenue" either reduces the "operating" loss or increases the "operating" profit to obtain the "bottom line" profit or loss.

This survey focuses analyses on "operating" results in the belief that operating information more accurately reflects the consequences of management and/or regulatory initiatives without adding other influences generally considered non-controllable.

However, it is recognized that some users of financial statements may look at the net results after all revenues and expenses if for no other reason than that the number is readily obtained and may seem to be more readily understandable. Because of their more limited utility, "bottom line" results are not analyzed as extensively as "operating" profits and losses.

The effects of "non-operating revenue" on individual hospital results caused some hospitals to change to "bottom line" profit from "operating" loss positions. Others remained in their original profit or loss position with "bottom line" results which were more favorable than their "operating" results. The summary below indicates a five-year comparison of "operating" losses and "bottom line" losses. A more detailed analysis of "bottom line" results by geographic location follows the summary below.

VOLUNTARY AND PUBLIC HOSPITAL
COMPARISON OF "OPERATING" AND "BOTTOM LINE" LOSSES

	"Operating" Losses		"Bottom Line" Losses	
	$ Million	Number	$ Million	Number
1975	$175	167	$126	115
1976	168	195	115	132
1977	230	198	169	153
1978	248	187	183	138
1979	267	195	201	148

VOLUNTARY AND PUBLIC HOSPITAL
ANALYSIS OF "BOTTOM LINE" RESULTS
(BEFORE IDENTIFIED GOVERNMENTAL SUBSIDIES)

Year	Region	"BOTTOM LINE" LOSSES $ Million	Number	% of Number State	% of Number Region	"BOTTOM LINE" PROFITS $ Million	Number	% of Number State	% of Number Region
1975	New York City	$ 53.1	34	14%	59%	$13.1	24	10%	41%
	Nassau-Suffolk	18.9	5	2	26	7.6	14	6	74
	Northern Met.	12.8	14	6	35	6.1	26	11	65
	Albany	1.7	10	4	36	7.1	18	7	64
	Utica	3.5	16	7	52	3.4	15	6	48
	Syracuse	10.6	9	4	47	3.4	10	4	53
	Rochester	8.3	8	3	47	1.7	9	4	53
	Buffalo	16.6	19	8	58	3.8	14	6	42
	State	$125.5	115	47%		$46.2	130	53%	
1976	New York City	$ 44.1	33	13%	57%	$18.2	25	10%	43%
	Nassau-Suffolk	11.8	3	1	16	5.7	16	7	84
	Northern Met.	19.7	22	9	55	3.1	18	7	45
	Albany	3.1	15	6	54	3.4	13	5	46
	Utica	2.5	19	8	61	1.4	12	5	39
	Syracuse	7.9	11	4	58	2.7	8	3	42
	Rochester	7.9	12	5	71	.8	5	2	29
	Buffalo	18.4	17	7	52	4.5	16	7	48
	State	$115.4	132	54%		$39.8	113	46%	
1977	New York City	$ 81.0	43	18%	74%	$ 9.3	15	6%	26%
	Nassau-Suffolk	17.9	8	3	42	8.8	11	4	58
	Northern Met.	28.3	28	11	70	6.1	12	5	30
	Albany	4.2	16	7	57	2.9	12	5	43
	Utica	3.8	20	8	65	1.4	11	4	35
	Syracuse	7.5	8	3	42	2.9	11	4	58
	Rochester	6.4	9	4	53	1.9	8	3	47
	Buffalo	19.7	21	9	64	3.3	12	5	36
	State	$168.8	153	62%		$36.6	92	38%	
1978	New York City	$ 89.5	41	17%	71%	$17.7	17	7%	29%
	Nassau-Suffolk	27.3	8	3	42	8.3	11	4	58
	Northern Met.	22.4	25	10	63	5.9	15	6	37
	Albany	6.1	17	7	61	2.7	11	4	39
	Utica	4.1	17	7	55	3.1	14	6	45
	Syracuse	13.7	8	3	42	4.5	11	4	58
	Rochester	1.7	3	1	18	4.6	14	6	82
	Buffalo	17.8	19	8	58	3.2	14	6	42
	State	$182.6	138	56%		$50.0	107	44%	
1979	New York City	$107.1	41	17%	71%	$10.5	17	7%	29%
	Nassau-Suffolk	23.6	10	4	53	6.9	9	4	47
	Northern Met.	18.3	26	11	65	7.7	14	6	35
	Albany	4.6	18	7	64	3.5	10	4	36
	Utica	2.9	14	6	45	4.0	17	7	55
	Syracuse	20.1	12	5	63	3.8	7	3	37
	Rochester	3.7	7	3	41	3.9	10	4	59
	Buffalo	20.4	20	8	61	3.6	13	5	39
	State	$200.7	148	60%		$43.9	97	40%	

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VOLUNTARY AND PUBLIC HOSPITAL
OPERATING RESULTS BY GEOGRAPHIC LOCATION

Year	Region	OPERATING LOSSES $ Million	Number	% of Number State	% of Number Region	OPERATING PROFITS $ Million	Number	% of Number State	% of Number Region
1975	New York City	$ 89.4	45	18%	78%	$ 4.4	13	5%	22%
	Nassau-Suffolk	20.4	9	4	47	2.6	10	4	53
	Northern Met.	16.5	27	11	68	1.1	13	5	32
	Albany	4.5	21	9	75	1.1	7	3	25
	Utica	5.9	23	9	74	.7	8	3	26
	Syracuse	11.2	11	4	58	1.8	8	3	42
	Rochester	9.4	10	4	59	.9	7	3	41
	Buffalo	18.0	21	9	64	2.1	12	5	36
	State	$175.3	167	68%		$14.7	78	32%	
1976	New York City	$ 75.8	49	20%	84%	$ 3.5	9	4%	16%
	Nassau-Suffolk	14.7	12	5	63	1.5	7	3	37
	Northern Met.	25.6	34	14	85	1.0	6	2	15
	Albany	5.7	22	9	79	1.4	6	2	21
	Utica	6.1	25	10	81	.5	6	2	19
	Syracuse	9.1	15	6	79	1.4	4	2	21
	Rochester	10.5	14	6	82	.4	3	1	18
	Buffalo	20.7	24	10	73	2.5	9	4	27
	State	$168.2	195	80%		$12.2	50	20%	
1977	New York City	$118.9	54	22%	93%	$ 4.5	4	2%	7%
	Nassau-Suffolk	20.7	8	3	42	5.1	11	4	58
	Northern Met.	35.4	36	15	90	2.5	4	2	10
	Albany	7.7	26	11	93	.5	2	1	7
	Utica	8.3	27	11	87	.4	4	2	13
	Syracuse	8.5	12	5	63	1.4	7	3	37
	Rochester	7.9	11	4	65	1.3	6	2	35
	Buffalo	22.4	24	10	73	1.5	9	4	27
	State	$229.8	198	81%		$17.2	47	19%	
1978	New York City	$131.1	51	21%	88%	$ 4.6	7	3%	12%
	Nassau-Suffolk	30.9	12	5	63	3.6	7	3	37
	Northern Met.	28.3	34	14	85	2.7	6	2	15
	Albany	9.9	24	10	86	.4	4	2	14
	Utica	8.1	23	9	74	1.3	8	3	26
	Syracuse	14.8	8	3	42	3.5	11	4	58
	Rochester	3.0	9	4	53	2.9	8	3	47
	Buffalo	21.4	26	11	79	.7	7	3	21
	State	$247.5	187	76%		$19.7	58	24%	
1979	New York City	$149.5	53	22%	91%	$ 4.9	5	2%	9%
	Nassau-Suffolk	29.9	13	5	68	1.9	6	2	32
	Northern Met.	24.5	32	13	80	2.9	8	3	20
	Albany	8.5	23	9	82	.8	5	2	18
	Utica	6.5	23	9	74	1.0	8	3	26
	Syracuse	19.4	13	5	68	2.2	6	2	32
	Rochester	4.8	8	3	47	1.7	9	4	53
	Buffalo	23.8	30	12	91	.7	3	1	9
	State	$266.9	195	80%		$16.1	50	20%	

SECTION II
VOLUNTARY HOSPITAL

HIGHLIGHTS

- 79.1% of New York State's voluntary hospitals operated in the red in 1979.
- Average voluntary hospital net operating losses increased 4.3% from $1.086 million in 1978 to $1.133 million in 1979.
- Aggregate voluntary hospital net operating losses increased over 13.8% from $159 million in 1978 to $181 million in 1979.
- Adjusted per diem costs rose 8.6% from 1978 to 1979 compared with an 11.8% increase for the nation.
- 95 voluntary hospitals operated in the red each year from 1975 through 1979 rolling up an aggregate $618 million loss an average of more than $1.3 million per hospital each year.
- Total "bottom line" losses rose 14.0% from $114 million in 1978 to $130 million in 1979 for voluntary hospitals
- Non-operating revenues (including contributions, bequests, other philanthropy, and income on endowments) of voluntary hospitals fell steadily from 2.1% of expenses in 1975 to 1.7% in 1979.
- $557 million of community equity in voluntary hospitals has been cannibalized to underwrite losses from 1975 through 1979. If the 1979 rate continues in the future, the $2 billion equity of the 220 voluntary hospitals will be consumed in 13 years and 7 months.
- Only 8 hospitals had <u>no</u> losses in any of the 5 years from 1975 to 1979.

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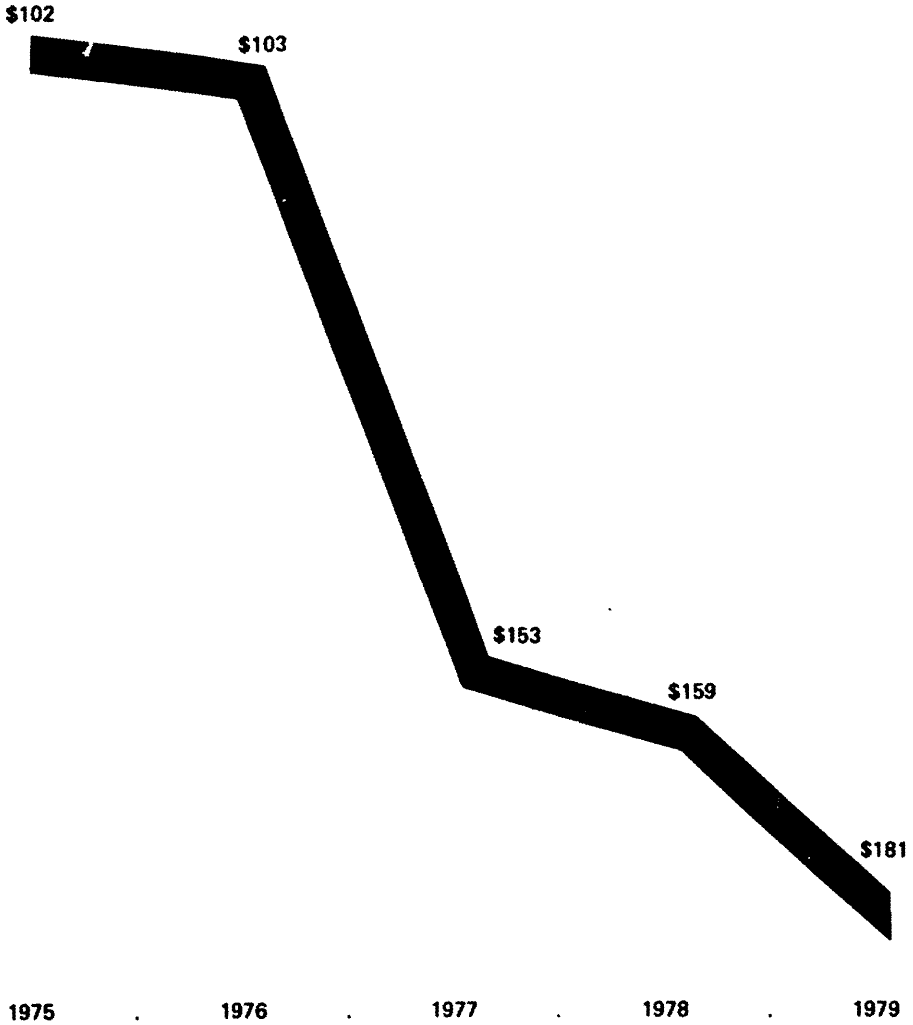
220 VOLUNTARY HOSPITALS
NET OPERATING LOSS TREND

	AGGREGATE NET OPERATING LOSSES	HOSPITALS WITH NET OPERATING LOSSES		HOSPITALS WITH NET OPERATING PROFITS	
	($ Million)	$ Million	Number	$ Million	Number
1975	$102	$116	146	$14	74
1975 to 1976: Increase/(Decrease)					
Amount	$1	$(1)	28	$(2)	(28)
Percent	1%	(1)%	19%	(14)%	(38)%
1976	$103	$115	174	$12	46
1976 to 1977: Increase/(Decrease)					
Amount	$50	$55	1	$5	(1)
Percent	49%	48%	1%	42%	(2)%
1977	$153	$170	175	$17	45
1977 to 1978: Increase/(Decrease)					
Amount	$6	$8	(11)	$2	11
Percent	4%	5%	(6)%	12%	24%
1978	$159	$178	164	$19	56
1978 to 1979: Increase/(Decrease)					
Amount	$22	$1[illegible]	10	$(3)	(10)
Percent	14%	11%	6%	(16)%	(18)%
1979	$181	$197	174	$16	46


220 VOLUNTARY HOSPITALS
NET OPERATING LOSS TREND
($ MILLIONS)
$102
$103
$153
$159
$181
1975
1976
1977
1978
1979

VOLUNTARY HOSPITAL
PROFIT AND LOSS SWINGS
FIVE-YEAR IMPACT
1975 – 1976 – 1977 – 1978 – 1979

	Number	Percent	Cumulative Percent	Aggregate Five Year Net Profit or (Loss) $ Million	Cumulative $ Million
Loss all 5 years	95	43%	43%	$(618)	$(618)
Loss 4 of 5 years	56	26	69	(87)	(705)
Loss 3 of 5 years	27	12	81	(36)	(741)
Loss 2 of 5 years	19	9	90	(2)	(743)
Subtotal of Net Losses	197	90	90	(743)	
Loss 1 of 5 years	15	7	7	20	(723)
Some profits each year	8	3	10	24	(699)
Subtotal of Net Profits	23	10	10	44	
Net Losses	220	100%	100%	$(699)	

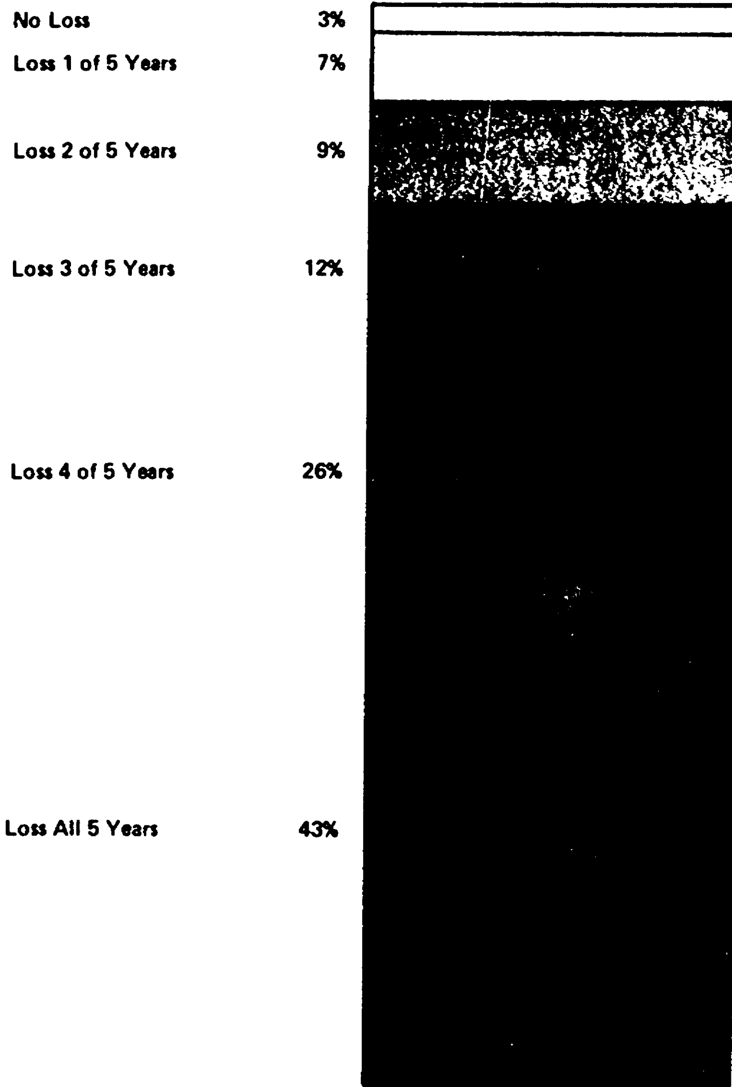
Ninety-five of the two hundred twenty voluntary hospitals studied suffered a loss for each of the five years – 1975 through 1979. Only eight hospitals (3%) were in the black for every one of the five years.

The hospitals which had operating losses in every one of the five years accounted for 43% of the total surveyed. Their aggregate five-year losses were $618 million – an average of more than $120 million every year.

On the average, each of the ninety-five hospitals in the red each year lost more than $1.3 million every year from 1975 through 1979. Conversely, the average annual operating profit of each of the eight hospitals in the black was only $ .6 million.

The cumulative impact of these operating results for the five years 1975 through 1979 is illustrated by the accompanying graph.

VOLUNTARY HOSPITAL
PROFIT AND LOSS SWINGS
FIVE-YEAR IMPACT
1975 through 1979



VOLUNTARY HOSPITAL
NON-OPERATING REVENUE

	$ Million	% of Expense
1975	$80	2.1%
1976	79	1.9
1977	79	1.8
1978*	85	1.7
1979	94	1.7

Unrestricted contributions, bequests, and other philanthropy are reported in the special "non-operating revenue" section of the financial reports. Unrestricted income earned on the invested proceeds of such philanthropy plus unrestricted income earned on endowments whose principal has been restricted as to use by the donor are also reported as "non-operating revenue". Both philanthropy and the income earned on unconsumed, invested philanthropy are important sources of revenue needed to defray expenses such as bad debts and free care not reimbursed by Blue Cross, Medicaid, No-Fault, or Workers' Compensation under New York State revenue controls.

While virtually every hospital surveyed reported some "non-operating revenue", twenty-nine hospitals reported more than $193 million, over 45%, of the total $426 million "non-operating revenue" for the five years 1975 through 1979. Nineteen of the twenty-nine hospitals reported "non-operating revenue" of at least $1 million in more than one of the five years.

During the five years under study, after application of "non-operating revenue", hospitals with "operating" losses still faced staggering "bottom line" losses. In order to meet payrolls and pay bills, these hospitals were forced to consume equity capital which might have taken many years to accumulate. This is somewhat analagous to an individual raiding savings to pay rent or to buy food. Many communities have relied upon these funds to assure (endow) the future of health care delivery to their citizens. Over one-half billion dollars of community investments in their voluntary hospitals have been consumed to meet "bottom line" losses in just the five years under study.

COMMUNITY EQUITY CONSUMED
($ MILLION)

1975	$ 84
1976	81
1977	123
1978	127
1979	142
Total	$557

Many hospitals' governing boards look upon this erosion of equity as a form of involuntary conversion or confiscation of assets. They view protection of these assets as one of their fiduciary responsibilities. Many have questioned whether governmental actions which restrict reimbursement to less than reasonable cost may be in violation of their constitutional rights. Certainly, these trends seem to threaten the future of voluntarism in health care and to undermine capital financing efforts through philanthropy. It is also notable that "non-operating revenues" represent an ever-decreasing proportion of expenses each year. This phenomenon has led some to question whether prospective donors may be discouraged in the belief that their philanthropy can do little to help health care institutions which were once a prime object of their interest.

*NOTE: In 1978, one hospital reported receipt of the proceeds of a trust in excess of $9 million. Due to the extraordinary nature of this transaction and to avoid distortion of year-to-year comparisons, the amount has been excluded from the $85 million in the table above.

VOLUNTARY HOSPITAL
EXPENSES

	Expenses ($ Million)	% of Increase
1975	$3,752	
1976	4,161	11%
1977	4,510	8
1978	4,919	9
1979	5,458	11

New York's hospitals have contained the rate of increase in expenses for 1979 below the general rate of inflation as measured by the Consumer Price Index.

Changes in the rate of increase in New York, using the American Hospital Association's adjusted per diem cost* statistical measure, seem to compare favorably with others in the nation. New York bettered the U.S. percentages every year in cost containment results. New York's five-year average was also lower than those of the nation, New Jersey and Pennsylvania. New York's adjusted per diem costs* might even be lower than those of the nation and other regions if geographic and economic differentials could be applied.

VOLUNTARY HOSPITAL
ADJUSTED PER DIEM COSTS

	New York		United States		New Jersey		Pennsylvania	
	Adjusted Per Diem Cost*	% Increase	Adjusted Per Diem Cost*	% Increase	Adjusted Per Diem Cost*	% Increase	Adjusted Per Diem Cost*	% Increase
1975	$153.95		$133.36		$126.36		$123.67	
1976	169.25	9.9%	152.94	14.7%	142.63	12.9%	141.45	14.4%
1977	185.94	9.9	174.68	14.2	160.09	12.2	162.15	14.6
1978	204.03	9.7	195.07	11.7	173.52	8.4	184.89	14.0
1979	221.48	8.6	218.06	11.8	192.68	11.0	208.89	13.0
1975 - 79		43.9%		63.5%		52.5%		68.9%

*NOTE: Adjusted per diem cost is calculated by dividing total expenses by total adjusted patient days which represent the aggregate total of inpatient days and weighted outpatient units of service.

A SECOND BASIS FOR ANALYSIS -- "BOTTOM LINE" RESULTS

Profits and losses are analyzed on two bases. The first basis focuses on "operating" results by subtracting total costs from total revenues exclusive of "non-operating revenue", which is reported in a separate section of the financial reports.

The second basis is referred to as "bottom line" results. "Non-operating revenue" either reduces the "operating" loss or increases the "operating" profit to obtain the "bottom line" profit or loss.

This survey focuses analyses on "operating" results in the belief that operating information more accurately reflects the consequences of management and/or regulatory initiatives without adding other influences generally considered non-controllable.

However, it is recognized that some users of financial statements may look at the net results after all revenues and expenses if for no other reason than that the number is readily obtained and may seem to be more readily understandable. Because of their more limited utility, "bottom line" results are not analyzed as extensively as "operating" profits and losses.

The effects of "non-operating revenue" on individual hospital results caused some hospitals to change to "bottom line" profit from "operating" loss positions. Others remained in their original profit or loss position with "bottom line" results which were more favorable than their "operating" results. The summary below indicates a five-year comparison of "operating" losses and "bottom line" losses. A more detailed analysis of "bottom line" results by geographic location follows the summary below.

VOLUNTARY HOSPITAL
COMPARISON OF "OPERATING" AND "BOTTOM LINE" LOSSES

	"Operating" Losses		"Bottom Line" Losses	
	$ Million	Number	$ Million	Number
1975	$116	146	$68	94
1976	115	174	63	114
1977	170	175	111	131
1978	178	164	114	116
1979	197	174	130	129

VOLUNTARY HOSPITAL
ANALYSIS OF "BOTTOM LINE" RESULTS

Year	Region	"BOTTOM LINE" LOSSES $ Million	Number	% of Number State	% of Number Region	"BOTTOM LINE" PROFITS $ Million	Number	% of Number State	% of Number Region
1975	New York City	$ 47.9	33	15%	58%	$ 13.1	24	11%	42%
	Nassau-Suffolk	3.0	4	2	22	7.6	14	6	78
	Northern Met.	2.3	13	6	33	6.1	26	12	67
	Albany	1.3	8	4	31	7.1	18	8	69
	Utica	2.7	11	5	48	3.1	12	5	52
	Syracuse	1.1	5	2	33	3.4	10	5	67
	Rochester	6.2	7	3	47	1.6	8	4	53
	Buffalo	3.1	13	6	48	3.8	14	6	52
	State	$ 67.6	94	43%		$ 45.8	126	57%	
1976	New York City	$ 36.3	32	15%	56%	$ 18.2	25	11%	44%
	Nassau-Suffolk	1.3	2	1	11	5.7	16	7	89
	Northern Met.	6.6	21	10	54	3.1	18	8	46
	Albany	2.9	13	6	50	3.4	13	6	50
	Utica	1.5	13	6	57	1.0	10	5	43
	Syracuse	3.1	8	4	53	2.7	7	3	47
	Rochester	6.5	11	5	73	.6	4	2	27
	Buffalo	4.7	14	6	52	4.1	13	6	48
	State	$ 62.9	114	52%		$ 38.8	106	48%	
1977	New York City	$ 75.0	42	19%	74%	$ 9.3	15	7%	26%
	Nassau-Suffolk	3.5	7	3	39	8.8	11	5	61
	Northern Met.	10.8	27	12	69	6.1	12	5	31
	Albany	4.0	14	6	54	2.9	12	5	46
	Utica	3.2	14	6	61	1.3	9	4	39
	Syracuse	.6	4	2	27	2.9	11	5	73
	Rochester	4.8	8	4	53	1.8	7	3	47
	Buffalo	8.6	15	7	56	3.3	12	5	44
	State	$110.5	131	60%		$ 36.4	89	40%	
1978	New York City	$ 82.7	40	18%	70%	$ 17.7	17	8%	30%
	Nassau-Suffolk	4.0	7	3	39	8.3	11	5	61
	Northern Met.	10.6	24	11	62	5.9	15	7	38
	Albany	5.1	15	7	58	2.7	11	5	42
	Utica	2.4	11	5	48	2.1	12	5	52
	Syracuse	1.0	4	2	27	4.5	11	5	73
	Rochester	.8	2	1	13	4.6	13	6	87
	Buffalo	7.4	13	6	48	3.2	14	6	52
	State	$114.0	116	53%		$ 49.0	104	47%	
1979	New York City	$ 96.4	40	18%	70%	$ 10.5	17	8%	30%
	Nassau-Suffolk	4.1	9	4	50	6.9	9	4	50
	Northern Met.	10.1	25	11	64	7.7	14	6	36
	Albany	3.8	17	8	65	3.5	9	4	35
	Utica	1.7	8	4	35	3.5	15	7	65
	Syracuse	1.2	8	4	53	3.8	7	3	47
	Rochester	3.2	5	2	33	3.9	10	5	67
	Buffalo	9.3	17	8	63	3.1	10	5	37
	State	$129.8	129	59%		$ 42.9	91	41%	

VOLUNTARY HOSPITAL
OPERATING RESULTS BY GEOGRAPHIC LOCATION

Year		OPERATING LOSSES $ Million	Number	% of Number State	% of Number Region	OPERATING PROFITS $ Million	Number	% of Number State	% of Number Region
1975	New York City	$ 84.1	44	20%	77%	$ 4.4	13	6%	23%
	Nassau-Suffolk	4.5	8	4	44	2.6	10	5	56
	Northern Met.	6.1	26	12	67	1.1	13	6	33
	Albany	3.8	19	9	73	1.1	7	3	27
	Utica	5.0	18	8	78	.5	5	2	22
	Syracuse	1.5	7	3	47	1.8	8	4	53
	Rochester	7.3	9	4	60	.8	6	3	40
	Buffalo	4.4	15	7	56	2.1	12	5	44
	State	$116.7	146	66%		$14.4	74	34%	
1976	New York City	$ 67.9	48	22%	84%	$ 3.5	9	4%	16%
	Nassau-Suffolk	4.1	11	5	61	1.5	7	3	39
	Northern Met.	12.5	33	15	85	1.0	6	3	15
	Albany	5.4	20	9	77	1.4	6	3	23
	Utica	5.0	19	9	83	.2	4	2	17
	Syracuse	4.0	11	5	73	1.4	4	2	27
	Rochester	9.1	13	6	87	.3	2	1	13
	Buffalo	6.7	19	9	70	2.3	8	4	30
	State	$114.7	174	79%		$11.6	46	21%	
1977	New York City	$112.9	53	24%	93%	$ 4.5	4	2%	7%
	Nassau-Suffolk	6.0	7	3	39	5.1	11	5	61
	Northern Met.	18.0	35	16	90	2.5	4	2	10
	Albany	7.1	24	11	92	.5	2	1	8
	Utica	7.6	20	9	87	.4	3	1	13
	Syracuse	1.4	8	4	53	1.4	7	3	47
	Rochester	6.1	10	5	67	1.2	5	2	33
	Buffalo	11.2	18	8	67	1.5	9	4	33
	State	$170.3	175	80%		$17.1	45	20%	
1978	New York City	$124.3	50	23%	88%	$ 4.6	7	3%	12%
	Nassau-Suffolk	7.6	11	5	61	3.6	7	3	39
	Northern Met.	16.5	33	15	85	2.7	6	3	15
	Albany	8.8	22	10	85	.4	4	2	15
	Utica	6.3	17	8	74	.4	6	3	26
	Syracuse	1.8	4	2	27	3.5	11	5	73
	Rochester	1.9	7	3	47	2.9	8	4	53
	Buffalo	10.9	20	9	74	.7	7	3	26
	State	$178.1	164	75%		$18.8	56	25%	
1979	New York City	$138.8	52	24%	91%	$ 4.9	5	2%	9%
	Nassau-Suffolk	10.1	12	5	67	1.9	6	3	33
	Northern Met.	16.3	31	14	79	2.9	8	4	21
	Albany	7.6	22	10	85	.8	4	2	15
	Utica	5.3	17	8	74	.7	6	3	26
	Syracuse	2.2	9	4	60	2.2	6	3	40
	Rochester	4.2	6	3	40	1.7	9	4	60
	Buffalo	12.6	25	11	93	.5	2	1	7
	State	$197.1	174	79%		$15.6	46	21%	

SECTION III
PUBLIC HOSPITAL

HIGHLIGHTS

- 84.0% of New York State's public hospitals operated in the red in 1979.
- Average public hospital net operating losses increased 10.0% from $3.017 million in 1978 to $3.319 million in 1979.
- 15 public hospitals operated in the red each year from 1975 through 1979 rolling up an aggregate $301 million loss – an average of more than $4.0 million per hospital each year.
- Total "bottom line" losses rose 3.4% from $68.6 million in 1978 to $70.9 million in 1979 for public hospitals.

PUBLIC HOSPITAL
PROFIT AND LOSS SWINGS
FIVE YEAR IMPACT
1975 1976 -- 1977 -- 1978 -- 1979

				Aggregate Five Year Net Profit or (Loss)	
	Number	Percent	Cumulative Percent	$ Million	Cumulative $ Million
Loss all 5 years	15	60%	60%	$(301)	$(301)
Loss 4 of 5 years	5	20	80	(6)	(307)
Loss 3 of 5 years	4	16	96	(1)	(308)
Subtotal of Net Losses	24	96	96	(308)	
Loss 2 of 5 years	1	4	4	*	(308)
Net Losses	25	100%	100%	$(308)	

* = Less than $500.000

Fifteen of the twenty-five public hospitals studied suffered a loss for each of the five years – 1975 through 1979. No hospitals were in the black for every one of the five years.

The hospitals which had operating losses in every one of the five years accounted for 60% of the total surveyed. Their aggregate five-year losses were $301 million -- an average of more than $60 million every year.

On the average, each of the fifteen hospitals in the red each year lost more than $4.0 million every year from 1975 through 1979.

PUBLIC HOSPITAL
ANALYSIS OF "BOTTOM LINE" RESULTS
(BEFORE IDENTIFIED GOVERNMENTAL SUBSIDIES)

Year	Region	"BOTTOM LINE" LOSSES $ Million	Number	% of Number State	% of Number Region	"BOTTOM LINE" PROFITS $ Million	Number	% of Number State	% of Number Region
1975	New York City	$ 5.3	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	15.9	1	4	100	–	–	–	–
	Northern Met.	10.4	1	4	100	–	–	–	–
	Albany	.5	2	8	100	–	–	–	–
	Utica	.8	5	20	63	.3	3	12	37
	Syracuse	9.5	4	16	100	–	–	–	–
	Rochester	2.0	1	4	50	.1	1	4	50
	Buffalo	13.5	6	24	100	–	–	–	–
	State	$57.9	21	84%		$ .4	4	16%	
1976	New York City	$ 7.9	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	10.5	1	4	100	–	–	–	–
	Northern Met.	13.0	1	4	100	–	–	–	–
	Albany	.1	2	8	100	–	–	–	–
	Utica	1.0	6	24	75	.4	2	8	25
	Syracuse	4.8	3	12	75	*	1	4	25
	Rochester	1.4	1	4	50	.2	1	4	50
	Buffalo	13.8	3	12	50	.4	3	12	50
	State	$52.5	18	72%		$ 1.0	7	28%	
1977	New York City	$ 6.0	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	14.5	1	4	100	–	–	–	–
	Northern Met.	17.4	1	4	100	–	–	–	–
	Albany	.2	2	8	100	–	–	–	–
	Utica	.6	6	24	75	.1	2	8	25
	Syracuse	6.9	4	16	100	–	–	–	–
	Rochester	1.6	1	4	50	.1	1	4	50
	Buffalo	11.1	6	24	100	–	–	–	–
	State	$58.3	22	88%		$ .2	3	12%	
1978	New York City	$ 6.8	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	23.3	1	4	100	–	–	–	–
	Northern Met.	11.8	1	4	100	–	–	–	–
	Albany	1.0	2	8	100	–	–	–	–
	Utica	1.7	6	24	75	1.0	2	8	25
	Syracuse	12.7	4	16	100	–	–	–	–
	Rochester	1.0	1	4	50	*	1	4	50
	Buffalo	10.3	6	24	100	–	–	–	–
	State	$68.6	22	88%		$1.0	3	12%	
1979	New York City	$10.7	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	19.5	1	4	100	–	–	–	–
	Northern Met.	8.2	1	4	100	–	–	–	–
	Albany	.8	1	4	50	*	1	4	50
	Utica	1.2	6	24	75	.4	2	8	25
	Syracuse	18.9	4	16	100	–	–	–	–
	Rochester	.5	2	8	100	–	–	–	–
	Buffalo	11.1	3	12	50	.6	3	12	50
	State	$70.9	19	76%		$1.0	6	24%	

* = Less than $50,000.

PUBLIC HOSPITAL
OPERATING RESULTS BY GEOGRAPHIC LOCATION

Year		OPERATING LOSSES				OPERATING PROFITS			
		$ Million	Number	% of Number State	% of Number Region	$ Million	Number	% of Number State	% of Number Region
1975	New York City	$ 5.3	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	15.9	1	4	100	–	–	–	–
	Northern Met.	10.4	1	4	100	–	–	–	–
	Albany	.7	2	8	100	–	–	–	–
	Utica	.9	5	20	63	.2	3	12	37
	Syracuse	9.7	4	16	100	–	–	–	–
	Rochester	2.1	1	4	50	.1	1	4	50
	Buffalo	13.6	6	24	100	–	–	–	–
	State	$58.6	21	84%		$ .3	4	16%	
1976	New York City	$ 7.9	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	10.6	1	4	100	–	–	–	–
	Northern Met.	13.0	1	4	100	–	–	–	–
	Albany	.3	2	8	100	–	–	–	–
	Utica	1.1	6	24	75	.3	2	8	25
	Syracuse	5.1	4	16	100	–	–	–	–
	Rochester	1.4	1	4	50	.1	1	4	50
	Buffalo	14.0	5	20	83	.2	1	4	17
	State	$53.4	21	84%		$ .6	4	16%	
1977	New York City	$ 6.0	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	14.7	1	4	100	–	–	–	–
	Northern Met.	17.4	1	4	100	–	–	–	–
	Albany	.6	2	8	100	–	–	–	–
	Utica	.7	7	28	88	*	1	4	12
	Syracuse	7.1	4	16	100	–	–	–	–
	Rochester	1.8	1	4	50	*	1	4	50
	Buffalo	11.2	6	24	100	–	–	–	–
	State	$59.5	23	92%		$ .1	2	8%	
1978	New York City	$ 6.8	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	23.3	1	4	100	–	–	–	–
	Northern Met.	11.8	1	4	100	–	–	–	–
	Albany	1.1	2	8	100	–	–	–	–
	Utica	1.8	6	24	75	.9	2	8	25
	Syracuse	13.0	4	16	100	–	–	–	–
	Rochester	1.1	2	8	100	–	–	–	–
	Buffalo	10.5	6	24	100	–	–	–	–
	State	$69.4	23	92%		$ .9	2	8%	
1979	New York City	$10.6	1	4%	100%	$ –	–	–%	–%
	Nassau-Suffolk	19.8	1	4	100	–	–	–	–
	Northern Met.	8.2	1	4	100	–	–	–	–
	Albany	.9	1	4	50	*	1	4	50
	Utica	1.3	6	24	75	.3	2	8	25
	Syracuse	17.1	4	16	100	–	–	–	–
	Rochester	.6	2	8	100	–	–	–	–
	Buffalo	11.2	5	20	83	.2	1	4	17
	State	$69.7	21	84%		$ .5	4	16%	

* = Less than $50,000.

SECTION IV

VITAL SIGNS

Selected statistics and financial information called "vital signs" are presented in this section. The data is presented in a number of ways to facilitate analyses according to the bases chosen.

Combined "vital signs" for the 245 voluntary and public hospitals presented in Section I of this survey are reported here both in summary for each of the five years 1975 through 1979 and also, by region for 1979. Also, separate "vital signs" for the 220 voluntary hospitals and for the 25 public hospitals are each reported by year and by region.

Other "vital signs" presentations include:

. Shrinkage over five years – voluntary and public hospitals

. New York Health and Hospitals Corporation

"VITAL SIGNS"
245 VOLUNTARY AND PUBLIC HOSPITALS*

	1975	1976	% CHANGE 1975-76	1977	% CHANGE 1976-77	1978	% CHANGE 1977-78	1979	% CHANGE 1978-79	AVERAGE ANNUAL % CHANGE 1975-79
ACUTE CARE										
INPATIENT (Adult and Pediatric)										
Beds	62,135	62,807	1.1%	62,813	-%	62,768	(.1)%	62,817	.1%	.3%
Average Beds Per Hospital	254	256	.8	256	-	256	-	256		2
Discharges	2,042,662	2,081,848	1.9	2,103,986	1.1	2,103,820		2,128,136	1.2	1.1
Days	19,580,867	19,825,895	1.3	19,418,979	(2.1)	19,449,261	2	19,651,999	1.0	1
Occupancy Rate	86.3%	86.2%	(.1)	84.7%	(1.7)	84.9%	2	85.7%	.9	(.2)
Average Days Stay	9.6	9.5	(1.0)	9.2	(3.2)	9.2	-	9.2		(1.1)
INPATIENT (Total **)										
Discharges	2,113,127	2,153,330	1.9	2,176,200	1.1	2,175,041	(.1)	2,199,438	1.1	1.0
Days	19,979,021	20,239,894	1.3	19,826,772	(2.0)	19,855,563	.1	20,058,151	1.0	1
Average Days Stay	9.5	9.4	(1.1)	9.1	(3.2)	9.1		9.1	-	(1.1)
Births	194,282	193,517	(.4)	198,348	2.5	194,672	(1.9)	195,316	.3	1
OUTPATIENT										
Clinic Visits	5,163,271	5,137,831	(.5)	5,322,221	3.6	5,201,639	(2.3)	5,459,136	5.0	1.4
Emergency Service Visits	4,820,335	5,060,910	5.0	5,069,265	.2	5,113,575	.9	5,219,841	2.1	2.1
HOSPITAL-BASED RESIDENTIAL HEALTH CARE FACILITIES										
Number of Facilities	52	57	9.6	57	-	57	--	57		2.4
Beds	3,548	3,734	5.2	4,247	13.7	4,238	(.2)	4,416	4.2	6.1
Average Beds Per Facility	68	66	(2.9)	75	13.6	74	(1.3)	77	4.1	3.3
Discharges	11,734	11,992	2.2	11,109	(7.4)	9,481	(14.7)	12,084	27.5	.8
Days	1,099,542	1,278,395	16.3	1,502,074	17.5	1,511,317	6	1,553,104	2.8	10.3
Occupancy Rate	84.9%	93.5%	10.1	96.9%	3.6	97.7%	.8	96.4%	(1.3)	3.4
Average Days Stay	93.7	106.6	13.8	135.2	26.8	159.4	17.9	128.5	(19.4)	9.3
PAYROLL										
Employees (Full-time Equivalents)	199,474	202,557	1.5	207,621	2.5	210,622	1.4	216,586	2.8	
Salaries ($ Million)	$2,384.2	$2,550.1	7.0	$2,715.2	6.5	$2,943.3	8.4	$3,219.9	9.4	
Salary Per Full-time Equivalent	$11,952	$12,590	5.3	$13,078	3.9	$13,974	6.9	$14,867	6.4	
Salaries ÷ Expenses	58.7%	56.7%	(3.4)	55.7%	(1.8)	55.3%	(.7)	54.4%	(1.6)	
COMPOSITE STATEMENT OF REVENUES AND EXPENSES ($ Million)										
Revenue from All Sources	$3,984.9	$4,421.2	10.9	$4,739.1	7.2	$5,191.9	9.6	$5,757.9	10.9	
Less – Non-operating Revenue	81.3	80.3	(1.2)	80.4	.1	95.2	18.4	93.9	(1.4)	
	3,903.6	4,340.9		4,658.7		5,096.7		5,664.0		
Expenses	4,064.2	4,496.8	10.6	4,871.3	8.3	5,324.5	9.3	5,914.7	11.1	
Net Operating (Losses)	$ (160.6)	$ (155.9)	2.9	$ (212.6)	(36.4)	$ (227.8)	(7.1)	$ (250.7)	(10.1)	

*Does not include New York City Health and Hospitals Corporation.
**Includes Routine Nursery at 1/3 and Premature Nursery.

SUMMARY OF VOLUNTARY AND PUBLIC* HOSPITAL
1979 "VITAL SIGNS" BY REGION

	Statewide	DOWNSTATE				UPSTATE					
	Statewide	Total Downstate	New York City	Nassau-Suffolk	Northern Metropolitan	Total Upstate	Albany	Utica	Syracuse	Rochester	Buffalo
NUMBER OF HOSPITALS	245	117	58	19	40	128	28	31	19	17	33
ACUTE CARE											
INPATIENT (Adult and Pediatric)											
Beds	62,817	39,399	25,683	6,100	7,616	23,418	5,180	3,283	4,605	3,409	6,941
Average Beds Per Hospital	256	337	443	321	190	183	185	106	242	201	210
Discharges	2,128,136	1,279,200	799,773	232,627	246,800	848,936	179,441	128,405	172,284	129,037	239,769
Days	19,651,999	12,420,499	8,130,593	2,037,687	2,252,219	7,231,500	1,672,728	952,476	1,399,726	1,064,551	2,142,019
Occupancy Rate	85.7%	86 4%	86 7%	91 5%	81 0%	84 6%	88 5%	79.5%	83 3%	85 6%	84.5%
Average Days Stay	9.2	9.7	10.2	8 8	9 1	8 5	9.3	7 4	8 1	8.2	8.9
INPATIENT (Total **)											
Discharges	2,199,438	1,324,081	828,668	241,423	253,990	875,357	185,041	132,210	177,898	134,130	246,078
Days	20,058,151	12,714,345	8,338,165	2,092,850	2,283,330	7,343,806	1,704,031	966,572	1,419,908	1,085,809	2,167,486
Average Days Stay	9 1	9 6	10 1	8 7	9 0	8 4	9 2	7 3	8 0	8.1	8 8
Births	195,316	120,236	75,641	23,709	20,886	75,080	13,593	11,428	17,517	13,667	18,875
OUTPATIENT											
Clinic Visits	5,459,136	4,282,900	3,691,823	370,718	220,359	1,176,236	127,011	159,934	212,595	379,634	297,062
Emergency Service Visits	5,219,841	3,023,936	1,768,609	607,711	647,616	2,195,905	499,480	347,187	428,764	295,890	624,584
HOSPITAL-BASED RESIDENTIAL HEALTH CARE FACILITIES											
Number of Facilities	57	9	6		3	48	4	20	7	9	8
Beds	4,416	1,177	1,062		115	3,239	230	1,197	391	1,025	396
Average Beds Per Facility	77	131	177		38	67	58	60	56	114	50
Discharges	12,084	3,473	3,272		201	8,611	131	939	2,531	1,467	3,543
Days	1,553,104	396,389	354,973		41,416	1,156,715	83,550	432,580	140,491	359,686	140,408
Occupancy Rate	96 4%	92 3%	91 6%	-	98 7%	97 8%	99 5%	99 0%	98 4%	96.1%	97.1%
Average Days Stay	128 5	114 1	108.5		206 0	134 3	637 8	460.7	55 5	245.2	39.6
PAYROLL											
Employees (Full-time Equivalents)	216 586	140,155	98,391	20,036	21,728	76,431	16,939	10,851	15,758	12,590	20,293
Salaries ($ Million)	$3,219 9	$2,325 1	$1,704 2	$317 0	$303 9	$894 8	$194.8	$118 9	$189.4	$165.5	$226.2
Salary Per Full-time Equivalent	$14,867	$16,589	$17,321	$15,822	$13,987	$11,707	$11,500	$10,958	$12,019	$13,145	$11,147
Salaries ÷ Expenses	54.4%	55 8%	56 5%	55 1%	53 3%	51 1%	52 9%	52.6%	50 8%	49 3%	50.4%
COMPOSITE STATEMENT OF REVENUES AND EXPENSES ($ Million)											
Revenue from All Sources	$5,757 9	$4,039 4	$2,921 8	$558 4	$559 2	$1,718 5	$367 2	$227 1	$356 6	$335.9	$431.7
Less Non-operating Revenue	93 9	70.2	47 9	11 3	11 0	23 7	6.6	6.5	9	3 3	6 4
	5,664.0	3,969 2	2,873 9	547.1	548 2	1,694 8	360 6	220 6	355 7	332 6	425.3
Expenses	5,914 7	4,163 3	3,018.4	575 1	569 8	1,751 4	368 3	226 1	372 9	335.7	448.4
Net Operating (Losses)	$ (250 7)	$ (194.1)	$ (144 5)	$(28 0)	$(21 6)	$(56 6)	$(7 7)	$(5 5)	$(17 2)	$(3 1)	$(23.1)

*Does not include New York City Health and Hospitals Corporation.
**Includes Routine Nursery at 1/3 and Premature Nursery

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"VITAL SIGNS"
220 VOLUNTARY HOSPITALS

	1975	1976	% CHANGE 1975-76	1977	% CHANGE 1976-77	1978	% CHANGE 1977-78	1979	% CHANGE 1978-79	AVERAGE ANNUAL % CHANGE 1975-79
ACUTE CARE										
INPATIENT (Adult and Pediatric)										
Beds	57,545	58,164	1.1%	58,218	.1%	58,223	%	58,297	1%	3%
Average Beds Per Hospital	262	264	.8	265	.4	265	–	265		3
Discharges	1,894,983	1,933,680	2 0	1,960,082	1 4	1,962,706	1	1,981,712	1 0	1 2
Days	18,266,045	18,532,281	1 5	18,160,437	(2 0)	18,169,118	-	18,343,143	1.0	1
Occupancy Rate	87 0%	87 1%	.1	85 5%	(1.8)	85.5%		86 2%	8	(2)
Average Days Stay	9.6	9 6	-	9 3	(3 1)	9 3	--	9 3	-	(8)
INPATIENT (Total*)										
Discharges	1,962,054	2,001,309	2 0	2,028,671	1.4	2,030,359	1	2,049,354	9	1 1
Days	18,641 559	18,920,003	1.5	18,545,259	(2 0)	18,553,387		18,726,098	9	1
Average Days Stay	9 5	9.5	--	9 1	(4.2)	9.1	-	9 1	-	(1.1)
Births	183,919	183,734	(1)	188,365	2.5	184,911	(1 8)	185,366	2	2
OUTPATIENT										
Clinic Visits	4,687,402	4,652,687	(7)	4,851,001	4 3	4,741,201	(2.3)	4,976,087	5.0	1.6
Emergency Service Visits	4,435,475	4,668,539	5.3	4,686,334	.4	4,719,565	.7	4,825,224	2.2	2.2
HOSPITAL-BASED RESIDENTIAL HEALTH CARE FACILITIES										
Number of Facilities	46	50	8.7	49	(2 0)	49	-	50	2.0	2 2
Beds	2,222	2,672	20.3	3,061	14 6	3,052	(3)	3,352	9.8	12.7
Average Beds Per Facility	48	53	10 4	62	17 0	62	-	67	8 1	9 9
Discharges	10,427	10,832	3.9	9,930	(8.3)	8,466	(14 7)	11,316	33.7	2.1
Days	723,985	906,365	25.2	1,084,083	19 6	1,091,634	.7	1,178,082	7.9	15 7
Occupancy Rate	89 3%	92 7%	3.8	97.0%	4.6	98.0%	1.0	96.3%	(1.7)	2.0
Average Days Stay	69.4	83 7	20.6	109.2	30 5	128 9	18.0	104.1	(19.2)	12.5
PAYROLL										
Employees (Full-time Equivalents)	184 737	187,056	1.3	192,283	2.8	194,861	1.3	200,258	2 8	
Salaries ($ Million)	$2,226.4	$2,383 7	7.1	$2,542.0	6 6	$2,753 5	8.3	$3,007.7	9 2	
Salary Per Full-time Equivalent	$12,052	$12,743	5 7	$13,220	3 7	$14,131	6.9	$15,019	6.3	
Salaries + Expenses	59.3%	57.3%	(3 4)	56.4%	(1.6)	56 0%	(.7)	55.1%	(1 6)	
COMPOSITE STATEMENT OF REVENUES AND EXPENSES										
($ Million)	$3,730.0	$4,137 0	10.9	$4,435.6	7 2	$4,853 9	9 4	$5,371 4	10.7	
Revenue from All Sources	80.5	79.0	(1.9)	79.1	.1	94 4	19.3	94.6	.2	
Less - Non-operating Revenue	3,649.5	4,058.0		4,356 5		4,759 5		5,276 8		
	3,751.8	4,161 1	10.9	4,509.7	8.4	4,918.8	9 1	5,458.3	11.0	
Expenses	$ (102.3)	$ (103.1)	(.8)	$ (153.2)	(48.6)	$ (159.3)	(4.0)	$ (181.5)	(13 9)	
Net Operating (Losses)										

*Includes Routine Nursery at 1/3 and Premature Nursery

SUMMARY OF VOLUNTARY HOSPITAL
1979 "VITAL SIGNS" BY REGION

	Statewide	DOWNSTATE				UPSTATE					
		Total Downstate	New York City	Nassau-Suffolk	Northern Metropolitan	Total Upstate	Albany	Utica	Syracuse	Rochester	Buffalo
NUMBER OF HOSPITALS	220	114	57	18	39	106	26	23	15	15	27
ACUTE CARE											
INPATIENT (Adult and Pediatric)											
Beds	58,297	38,006	25,311	5,494	7,201	20,291	5,028	2,560	3,571	3,299	5,833
Average Beds Per Hospital	265	333	444	305	185	191	193	111	238	220	216
Discharges	1,981,712	1,238,126	787,682	212,951	237,493	743,586	174,521	98,616	137,417	127,427	205,605
Days	18,343,143	11,999,566	8,012,176	1,853,533	2,133,857	6,343,577	1,627,863	754,733	1,112,742	1,039,411	1,808,828
Occupancy Rate	86.2%	86.5%	86.7%	92.4%	81.2%	85.7%	88.7%	80.8%	85.4%	86.3%	85.0%
Average Days Stay	9.3	9.7	10.2	8.7	9.0	8.5	9.3	7.7	8.1	8.2	8.8
INPATIENT (Total **)											
Discharges	2,049,354	1,281,525	816,007	220,836	244,683	767,828	180,059	101,412	142,370	132,520	211,468
Days	18,726,098	12,278,294	8,217,663	1,895,663	2,164,968	6,447,804	1,658,909	765,238	1,130,478	1,060,669	1,832,510
Average Days Stay	9.1	9.6	10.1	8.6	8.8	8.4	9.2	7.5	7.9	8.0	8.7
Births	185,366	116,805	73,788	22,131	20,886	68,561	13,399	8,447	15,489	13,667	17,559
OUTPATIENT											
Clinic Visits	4,976,087	3,989,984	3,634,581	187,290	168,113	986,103	127,011	159,934	139,446	371,615	188,097
Emergency Service Visits	4,825,224	2,915,653	1,768,609	517,299	629,745	1,909,571	481,250	276,929	320,220	292,358	538,814
HOSPITAL BASED RESIDENTIAL HEALTH CARE FACILITIES											
Number of Facilities	50	9	6	-	3	41	4	15	7	8	7
Beds	3,352	1,177	1,062	-	115	2,175	230	779	391	451	324
Average Beds Per Facility	67	131	177	-	38	53	58	52	56	56	46
Discharges	11,316	3,473	3,272	-	201	7,843	131	647	2,531	1,087	3,447
Days	1,178,082	396,389	354,973	-	41,416	781,693	83,550	280,531	140,491	161,955	115,166
Occupancy Rate	96.3%	92.3%	91.6%	-	98.7%	98.5%	99.5%	98.7%	98.4%	98.4%	97.4%
Average Days Stay	104.1	114.1	108.5		206.0	99.7	637.8	433.6	55.5	149.0	33.4
PAYROLL											
Employees (Full-time Equivalents)	200,258	134,065	96,673	17,161	20,231	66,193	16,522	8,656	12,223	11,797	16,995
Salaries ($ Million)	$3,007.7	$2,230.0	$1,680.6	$271.9	$277.5	$777.7	$191.0	$96.6	$146.5	$156.7	$186.9
Salary Per Full-time Equivalent	$15,019	$16,634	$17,384	$15,844	$13,717	$11,749	$11,560	$11,160	$11,986	$13,283	$10,997
Salaries ÷ Expenses	55.1%	56.2%	56.7%	56.1%	53.8%	52.1%	53.1%	52.8%	52.2%	49.7%	52.8%
COMPOSITE STATEMENT OF REVENUES AND EXPENSES ($ Million)											
Revenue from All Sources	$5,371.4	$3,880.2	$2,879.4	$487.8	$513.0	$1,491.2	$359.8	$184.9	$283.2	$315.8	$347.5
Less Non-operating Revenue	94.6	69.9	48.0	10.9	11.0	24.7	6.6	6.4	2.6	3.2	5.9
	5,276.8	3,810.3	2,831.4	476.9	502.0	1,466.5	353.2	178.5	280.6	312.6	341.6
Expenses	5,458.3	3,965.8	2,965.3	485.0	515.5	1,492.5	360.0	183.0	280.6	315.1	353.8
Net Operating (Losses)	$(181.5)	$(155.5)	$(133.9)	$(8.1)	$(13.5)	$(26.0)	$(6.8)	$(4.5)	$(*)	$(2.5)	$(12.2)

*Less than $50,000
**Includes Routine Nursery at 1.3 and Premature Nursery

"VITAL SIGNS"
25 PUBLIC HOSPITALS*

	1975	1976	% CHANGE 1975-76	1977	% CHANGE 1976-77	1978	% CHANGE 1977-78	1979	% CHANGE 1978-79	AVERAGE ANNUAL % CHANGE 1975-79
ACUTE CARE										
INPATIENT (Adult and Pediatric)										
Beds	4,590	4,643	1 2%	4,595	(1 0)%	4,545	(1 1)%	4,520	(.6)%	(.4)%
Average Beds Per Hospital	184	186	1 1	184	(1 1)	182	(1 1)	181	(.5)	(.4)
Discharges	147,679	148,168	3	143,904	(2 9)	141,114	(1 9)	146,424	3.8	(.2)
Days	1,314,822	1,293,614	(1.6)	1,258,542	(2 7)	1,280,143	1 7	1,308,856	2.2	(.1)
Occupancy Rate	78 5%	76.1%	(3 1)	75 0%	(1 4)	77.2%	2 9	79.3%	2.7	3
Average Days Stay	8 9	8.7	(2 2)	8 7	--	9.1	4 6	8 9	(2 2)	–
INPATIENT (Total **)										
Discharges	151,073	152,021	.6	147,528	(3.0)	144,682	(1 9)	150,084	3 7	(.2)
Days	1,337,462	1,319,892	(1 3)	1,281,512	(2 9)	1,302,176	1 6	1,332,053	2 3	(.1)
Average Days Stay	8 9	8 7	(2 2)	8 7	–	9 0	3.4	8 9	(1 1)	
Births	10,363	9,783	(5.6)	9,983	2.0	9,761	(2 2)	9,950	1.9	(1.0)
OUTPATIENT										
Clinic Visits	475,869	485,144	1 9	471,220	(2 9)	460,438	(2 3)	483,049	4 9	.4
Emergency Service Visits	384,860	392,371	2.0	382,931	(2 4)	394,010	2 9	394,617	.2	6
HOSPITAL-BASED RESIDENTIAL HEALTH CARE FACILITIES										
Number of Facilities	6	7	16.7	8	14.3	8	–	7	(12 5)	4 2
Beds	1,326	1,062	(19.9)	1,186	11.7	1,186	-	1,064	(10.3)	(5.0)
Average Beds Per Facility	221	152	(31 2)	148	(2.6)	148	–	152	2 7	(7.8)
Discharges	1,307	1,160	(11.2)	1,179	1.6	1,015	(13.9)	768	(24 3)	(10.3)
Days	375,557	372,030	(.9)	417,991	12.4	419,683	.4	375,022	(10.6)	–
Occupancy Rate	77 6%	95.7%	23.3	96.6%	.9	96.9%	3	96.6%	(.3)	6.1
Average Days Stay	287 3	320.7	11 6	354 5	10.5	413.5	16.6	488.3	18 1	17 5
PAYROLL										
Employees (Full-time Equivalents)	14,737	15,501	5.2	15,338	(1 1)	15,761	2.8	16,328	3.6	
Salaries ($ Million)	$157.8	$166.4	5 4	$173.2	4.1	$189 8	9 6	$212 2	11.8	
Salary Per Full-time Equivalent	$10,708	$10,735	.3	$11,292	5.2	$12,042	6 6	$12,996	7.9	
Salaries÷Expenses	50.5%	49.6%	(1.8)	47.9%	(3.4)	46.8%	(2.3)	46.5%	(.6)	
COMPOSITE STATEMENT OF REVENUES AND EXPENSES ($ Million)										
Revenue from All Sources	$254.9	$284.2	11.5	$303.5	6.8	$338.0	11.4	$386 5	14.3	
Less – Non-operating Revenue	.8	1.3	62.5	1.3	–	.8	(38.5)	(.7)		
	254.1	282.9		302.2		337.2		387.2		
Expenses	312.4	335.7	7.5	361.6	7.7	405.7	12.2	456.4	12.5	
Net Operating (Losses)	$ (58.3)	$ (52.8)	9.4	$ (59.4)	(12.5)	$ (68.5)	(15.3)	$ (69.2)	(1.0)	

*Does not include New York City Health and Hospitals Corporation.
**Includes Routine Nursery at 1/3 and Premature Nursery.

SUMMARY OF PUBLIC** HOSPITAL 1979 "VITAL SIGNS" BY REGION

		DOWNSTATE				UPSTATE					
	Statewide	Total Downstate	New York City	Nassau-Suffolk	Northern Metropolitan	Total Upstate	Albany	Utica	Syracuse	Rochester	Buffalo
NUMBER OF HOSPITALS	25	3	1	1	1	22	2	8	4	2	6
ACUTE CARE											
INPATIENT (Adult and Pediatric)											
Beds	4,520	1,393	372	606	415	3,127	152	723	1,034	110	1,108
Average Beds Per Hospital	181	464	372	606	415	142	76	90	259	55	185
Discharges	146,424	41,074	12,091	19,676	9,307	105,350	4,920	29,789	34,867	1,610	34,164
Days	1,308,856	420 933	118,417	184,154	118,362	887,923	44,865	197,743	286,984	25,140	333,191
Occupancy Rate	79 3%	82.8%	87.2%	83.3%	78.1%	77.8%	80.9%	74.9%	76.0%	62.6%	82.4%
Average Days Stay	8.9	10.2	9.8	9.4	12.7	8.4	9.1	6.6	8.2	15.6	9.8
INPATIENT (Total***)											
Discharges	150,084	42,555	12,661	20,587	9,307	107,529	4,983	30,798	35,527	1,610	34,611
Days	1,332,053	436,051	120,502	197,187	118,362	896,001	45,122	201,334	289,429	25,140	334,976
Average Days Stay	8.9	10.2	9.5	9.6	12.7	8.3	9.1	6.5	8.1	15.6	9.7
Births	9,950	3,431	1,853	1,578	–	6,519	194	2,981	2,028	–	1,316
OUTPATIENT											
Clinic Visits	483,049	292,916	57,242	183,428	52,246	190,133	–	–	73,149	8,019	108,965
Emergency Service Visits	394,617	108,283	–	90,412	17,871	286,334	18,230	70,258	108,544	3,532	85,770
HOSPITAL BASED RESIDENTIAL HEALTH CARE FACILITIES											
Number of Facilities	7	–	–	–	–	7	–	5	–	1	1
Beds	1,064	–	–	–	–	1,064	–	418	–	574	72
Average Beds Per Facility	152	–	–	–	–	152	–	84	–	574	72
Discharges	768	–	–	–	–	768	–	292	–	380	96
Days	375,022	–	–	–	–	375,022	–	152,049	–	197,731	25,242
Occupancy Rate	96 6%	–	–	–	–	96.6%	–	99.7%	–	94.4%	96.1%
Average Days Stay	488 3	–	–	–	–	488.3	–	520.7	–	520.3	262.9
PAYROLL											
Employees (Full-time Equivalents)	16,328	6,090	1,718	2,875	1,497	10,238	417	2,195	3,535	793	3,298
Salaries ($ Million)	$212.2	$95.0	$23.5	$45.1	$26.4	$117 2	$3.9	$22.3	$42.9	$8.8	$39.3
Salary Per Full-time Equivalent	$12,996	$15,599	$13,679	$15,687	$17,635	$11,448	$9,353	$10,159	$12,136	$11,097	$11,916
Salaries ÷ Expenses	46 5%	48 1%	44 3%	50.1%	48.5%	45.3%	47.6%	51.7%	46.5%	42.7%	41.5%
COMPOSITE STATEMENT OF REVENUES AND EXPENSES ($ Million)											
Revenue from All Sources	$386 5	$159 3	$42.5	$70 6	$46.2	$227.2	$7.4	$42.3	$73.3	$20.1	$84.1
Less – Non-operating Revenue	(.7)	3	*	.3	–	(1.0)	.1	.2	(1.8)	.1	.4
	387 2	159.0	42.5	70.3	46.2	228.2	7.3	42.1	75.1	20.0	83.7
Expenses	456.4	197 6	53.1	90.1	54.4	258.8	8.2	43.1	92.2	20 6	94.7
Net Operating (Losses)	$(69 2)	$(38 6)	$(10.6)	$(19.8)	$(8.2)	$(30.6)	$(.9)	$(1.0)	$(17.1)	$(.6)	$(11.0)

*Less than $50,000.
**Does not include New York City Health and Hospitals Corporation.
***Includes Routine Nursery at 1/3 and Premature Nursery.

"VITAL SIGNS"
SHRINKAGE OVER 5 YEARS
VOLUNTARY AND PUBLIC HOSPITALS
Including New York City Health and Hospitals Corporation

	1975	1976	% CHANGE 1975-76	1977	% CHANGE 1976-77	1978	% CHANGE 1977-78	1979	% CHANGE 1978-79	AVERAGE ANNUAL % CHANGE 1975-79
NUMBER OF HOSPITALS	275	271	(1.5)%	265	(2.2)%	263	(.8)%	263	–%	(1.1)%
ACUTE CARE										
INPATIENT (Adult and Pediatric)										
Beds	74,279	74,380	.1	72,629	(2.4)	72,209	(.6)	71,960	(.3)	(.8)
Average Beds Per Hospital	270	274	1.5	274	–	275	.4	274	(.4)	.4
Discharges	2,322,383	2,346,570	1.0	2,323,924	(1.0)	2,329,419	.2	2,365,490	1.5	.5
Days	23,034,630	23,098,319	.3	22,116,133	(4.3)	22,088,522	(.1)	22,313,658	1.0	(.8)
Occupancy Rate	85.0%	84.8%	(.2)	83.4%	(1.7)	83.8%	.5	85.0%	1.4	–
Average Days Stay	9.9	9.8	(1.0)	9.5	(3.1)	9.5	–	9.4	(1.1)	(1.3)
INPATIENT (Total*)										
Discharges	2,404,449	2,429,793	1.1	2,407,590	(.9)	2,412,347	.2	2,448,982	1.5	.5
Days	23,519,822	23,596,419	.3	22,606,730	(4.2)	22,582,379	(.1)	22,813,262	1.0	(.8)
Average Days Stay	9.8	9.7	(1.0)	9.4	(3.1)	9.4	–	9.3	(1.1)	(1.3)
Births	221,306	220,004	(.6)	222,209	1.0	218,855	(1.5)	224,112	2.4	.3
OUTPATIENT										
Clinic Visits	8,958,439	8,815,702	(1.6)	8,418,490	(4.5)	8,210,119	(2.5)	8,557,227	4.2	(1.1)
Emergency Service Visits	6,464,872	6,627,623	2.5	6,480,929	(2.2)	6,566,940	1.3	6,614,273	.7	.6
HOSPITAL-BASED RESIDENTIAL HEALTH CARE FACILITIES										
Number of Facilities	58	63	8.6	62	(1.6)	62	–	62	–	1.7
Beds	5,550	5,756	3.7	6,004	4.3	5,995	(.1)	6,173	3.0	2.8
Average Beds Per Facility	96	91	(5.2)	97	6.6	97	–	100	3.1	1.1
Discharges	13,877	13,867	(.1)	12,736	(8.2)	10,302	(19.1)	13,364	29.7	(.9)
Days	1,686,172	1,885,874	11.8	2,106,549	11.7	2,114,576	.4	2,135,769	1.0	6.7
Occupancy Rate	83.2%	89.5%	7.6	96.1%	7.4	96.6%	.5	94.8%	(1.9)	3.5
Average Days Stay	121.5	136.0	11.9	165.4	21.6	205.3	24.1	159.8	(22.2)	7.9
PAYROLL										
Employees (Full-time Equivalents)	253,879	249,278	(1.8)	250,854	.6	252,977	.8	258,251	2.1	
Salaries ($ Million)	$3,108.1	$3,262.0	5.0	$3,349.5	2.7	$3,651.8	9.0	$3,934.6	7.7	
Salary Per Full-time Equivalent	$12,242	$13,086	6.9	$13,352	2.0	$14,435	8.1	$15,236	5.5	
Salaries ÷ Expenses	60.4%	58.4%	(3.3)	56.7%	(2.9)	56.7%	–	55.7%	(1.8)	
COMPOSITE STATEMENT OF REVENUES AND EXPENSES ($ Million)										
Revenue from All Sources	$4,812.0	$5,349.2	11.2	$5,280.0	(1.3)	$5,870.7	11.2	$6,424.4	9.4	
Less – Non-operating Revenue	85.0	81.1		81.9		101.6		101.6		
	4,727.0	5,268.1		5,198.1		5,769.1		6,322.8		
Expenses	5,146.9	5,585.4	8.5	5,904.6	5.7	6,440.4	9.1	7,065.8	9.7	
Net Operating (Losses)	$(419.9)	$(317.3)		$(706.5)		$(671.3)		$(743.0)		

*Includes Routine Nursery at 1/3 and Premature Nursery.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
"VITAL SIGNS"

	1975	1976	% CHANGE 1975-76	1977	% CHANGE 1976-77	1978	% CHANGE 1977-78	1979	% CHANGE 1978-79	AVERAGE ANNUAL % CHANGE 1975-79
NUMBER OF HOSPITALS	19	18	(5.3)%	18	-%	18	-%	18	-%	(1.3)%
ACUTE CARE										
INPATIENT (Adult and Pediatric)										
Beds	10,701	10,364	(3.1)	9,542	(7.9)	9,441	(1.1)	9,143	(3.2)	(3.7)
Average Beds Per Hospital	563	576	2.3	530	(8.0)	525	(.9)	508	(3.2)	(2.5)
Discharges	239,483	233,093	(2.7)	213,980	(8.2)	225,599	5.4	237,354	5.2	(.2)
Days	3,041,469	2,917,548	(4.1)	2,619,649	(10.2)	2,639,261	.7	2,661,659	.8	(3.1)
Occupancy Rate	77.9%	76.9%	(1.3)	75.2%	(2.2)	76.6%	1.9	79.8%	4.2	.6
Average Days Stay	12.7	12.5	(1.6)	12.2	(2.4)	11.7	(4.1)	11.2	(4.3)	(3.0)
INPATIENT (Total*)										
Discharges	250,412	244,228	(2.5)	225,432	(7.7)	237,306	5.3	249,545	5.2	(.1)
Days	3,125,293	2,998,586	(4.1)	2,702,453	(9.9)	2,726,816	.9	2,755,111	1.0	(3.0)
Average Days Stay	12.5	12.3	(1.6)	12.0	(2.4)	11.5	(4.2)	11.0	(4.3)	(3.0)
Births	24,889	24,670	(.9)	23,861	(3.3)	24,183	1.3	28,796	19.1	3.9
OUTPATIENT										
Clinic Visits	3,653,087	3,609,649	(1.2)	3,078,534	(14.7)	3,008,480	(2.3)	3,098,091	3.0	(3.8)
Emergency Service Visits	1,564,559	1,497,988	(4.3)	1,396,229	(6.8)	1,453,365	4.1	1,394,432	(4.1)	(2.7)
HOSPITAL BASED RESIDENTIAL HEALTH CARE FACILITIES										
Number of Facilities	5	6	20.0	5	(16.7)	5	-	5	-	-
Beds	1,922	2,022	5.2	1,757	(13.1)	1,757	-	1,757	-	(2.2)
Average Beds Per Facility	384	337	(12.2)	351	4.2	351	-	351	-	(2.2)
Discharges	2,077	1,875	(9.7)	1,627	(13.2)	821	(49.5)	1,280	55.9	(9.6)
Days	557,609	607,479	8.9	604,475	(.5)	603,259	(.2)	582,665	(3.4)	1.1
Occupancy Rate	79.5%	82.1%	3.3	94.3%	14.9	94.1%	(.2)	90.9%	(3.4)	3.6
Average Days Stay	268.5	324.0	20.7	371.5	14.7	734.8	97.8	455.2	(38.1)	17.4
PAYROLL										
Employees (Full-time Equivalents)	50,384	43,410	(13.8)	42,385	(2.4)	42,355	(.1)	41,665	(1.6)	
Salaries ($ Million)	$676.3	$670.5	(.9)	$622.9	(7.1)	$708.5	13.7	$714.7	.9	
Salary Per Full-time Equivalent	$13,423	$15,446	15.1	$14,696	(4.9)	$16,728	13.8	$17,153	2.5	
Salaries ÷ Expenses	67.1%	65.9%	(1.8)	61.2%	(7.1)	63.5%	3.8	62.1%	(2.2)	
COMPOSITE STATEMENT OF REVENUES AND EXPENSES ($ Million)										
Revenue from All Sources	$760.8	$868.0	14.1	$527.9	(39.2)	$678.8	28.6	$666.5	(1.8)	
Less Non-operating Revenue	2.9			1.4		6.4		7.7		
	757.9	868.0		526.5		672.4		658.8		
Expenses	1,007.9	1,016.9	.9	1,017.2		1,115.9	9.7	1,151.1	3.2	
Net Operating (Losses)	$(250.0)	$(148.9)		$(490.7)		$(443.5)		$(492.3)		

*Includes Routine Nursery at 1/3 and Premature Nursery

SECTION V

NOTES

MEDICAID SETTLEMENT – JAMAICA HOSPITAL vs BLUM

On December 3, 1979 settlement was ordered in the Jamaica Hospital vs Blum lawsuit. HANYS' member hospitals in 1976 sued the Commissioner of Health in HANYS vs Toia on his implementation of 1976 reimbursement rates prior to approval by the Secretary of the United State Department of Health, Education and Welfare. On November 9, 1976 in the so-called Lasker decision, the Commissioner of Health was ordered to recalculate rates for the period from January 1 to August 15, 1976. The additional monies were paid in 1977. The United States Congress then retroactively repealed the statute that had given the federal court jurisdiction to award relief to the hospitals. The federal court then vacated its prior judgment and directed, in September 1977, that hospitals promptly refund the money they had received earlier in 1977. The hospitals then commenced action in Jamaica Hospital vs Blum to seek relief in regard to the recoupment.

Under terms of the December 3, 1979 settlement, new rates for the years 1976, 1977, 1978 and 1979 were published at various times in 1980 to reflect the agreement and the resolution of outstanding appeals as of July 1, 1979 as part of that agreement. It is not known whether hospitals accrued the additional monies in 1979 or whether revenues were recorded in the years in which they were received. Because of differences in timing, separate identification of their impacts on the 1976, 1977, 1978 and 1979 financial reports was not undertaken.

ECONOMIC STABILIZATION PROGRAM LITIGATION SETTLEMENT

The federal Economic Stabilization Program (ESP) was imposed on August 15, 1971, and expired on April 30, 1974. HANYS' member hospitals sued the Commissioner of Health on his imposition of an ESP ceiling in the 1973 Medicaid rate formula. Also, hospitals in the seventeen downstate counties sued Blue Cross and Blue Shield of Greater New York on a similar ESP ceiling in its 1973 formula. Decisions for the hospitals in both actions resulted in additional payments to those hospitals whose original 1973 rates had been held to the ceilings. It is not known whether any hospitals anticipated the payments or the court victory by accruing the additional revenues in 1973 or in 1974 or whether revenues were recorded in the years in which they were received.

The additional Medicaid payments attributable to 1973, estimates of which aggregated as much as $41 million, were added to each affected hospital's 1975 inpatient and outpatient reimbursement rates to be paid based upon 1975 utilization. Downstate Blue Cross made lump-sum payments at the end of 1974. It had been estimated that 1974 Downstate Blue Cross payments to hospitals in the New York City, Nassau-Suffolk, and Northern Metropolitan areas might have aggregated $10 million. Because of differences in the timing and in the manner of payment of the Medicaid and Downstate Blue Cross settlements, separate identification of their impacts on 1975 financial reports was not undertaken.

ALLOCATIONS TO DIFFERENT SERVICES OR LEVELS OF CARE

Amounts reported on the financial reports combine those attributable to acute inpatient, residential health care, rehabilitative, ambulatory, home health, and all other hospital-based services. The financial reports do not provide the means to identify or to segregate or to allocate revenues, expenses, assets, liabilities, and fund balances by service on a direct or consistent or comparable basis. Therefore, this study treats the financial report data on a total institutional basis for dollars and for statistics except where separately and consistently identified.

COMMON FISCAL YEAR

State regulations were amended on October 9, 1975, to require that all Uniform Financial Reports (UFR's) be on a calendar year basis starting January 1, 1977. Hospitals in the seventeen counties served by Blue Cross and Blue Shield of Greater New York already had been reporting on a calendar year, so the rule change only affected a number of upstate hospitals. In order to include as many hospitals as possible in this survey, UFR data for fiscal years ending in either 1975 or 1976 but on dates other than December 31 of those years have been included.

AMOUNTS AND ROUNDING

A primary goal in preparing this survey was that it be easy to read and to grasp. We have rounded to the nearest whole million dollars and/or whole percentage wherever possible and/or practicable and/or appropriate. As a result, the sum of individual items may not add exactly to indicated totals even though all calculations were verified for accuracy before rounding.

ACCRUAL ACCOUNTING

Generally accepted accounting principles require accruai of unrecorded revenues and/or expenses to match costs and revenues within the same accounting period. When the auditor's opinion and/or the notes to the financial statements indicated circumstances requiring consideration for purposes of this analysis, appropriate adjustments were made. In the absence of such indication and because each financial report must have a CPA's opinion, it has been assumed that each financial report was prepared based upon generally accepted accounting principles. While subsequent events may reveal items not adequately provided for, it is unlikely that they would be of such magnitude to materially affect the overall significance of this study. It should be noted that the New York City Health and Hospitals Corporation made a change in 1977 to the cash basis for reporting revenues from the accrual basis which had been used in 1976 and in prior years. The amount of this change is not available from the Corporation.

UNREALIZED GAINS OR LOSSES ON MARKETABLE SECURITIES

A few hospitals have identified and reported as revenues or expenses unrealized gains or losses on marketable securities in unrestricted investment accounts. Amounts so reported have been excluded from this study to insure comparability and to avoid distortions.

GEOGRAPHIC REGIONS

Survey comparisons were based on the following Blue Cross regions:

New York City –
Nassau-Suffolk –
Northern Metropolitan –
Blue Cross of Greater New York

Albany –
Blue Cross of Northeastern New York

Utica –
Hospital Plan, Inc.
Hospital Service Corporation of Jefferson County

Syracuse –
Blue Cross of Central New York

Rochester –
Rochester Hospital Service Corporation

Buffalo –
Blue Cross of Western New York

Senator CHAFEE. Well, I want to thank all the witnesses, and this concludes the hearing.

Whereupon, at 11:50 a.m., the hearing adjourned subject to the call of the Chair.

SPENDING REDUCTION PROPOSALS

WEDNESDAY, APRIL 1, 1981

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D. C.

The committee met, pursuant to notice, at 9:35 a.m., in room 2221, Dirksen Senate Office Building, Hon. Robert J. Dole (chairman of the committee) presiding.

Present: Senators Dole, Durenberger, Heinz, Armstrong, Grassley, Long, Byrd, Bentsen, and Bradley.

Senator DURENBERGER. The hearing will come to order.

The Finance Committee today will continue its hearings on the President's budget proposal. We will focus today on the specific aspects of the budget that relate to maternal and child health services.

The administration has proposed that title V of the Social Security Act be repealed, that the programs that have been previously funded by that section be included in one of four health block grants and that the total Federal funding be reduced by 25 percent.

In addition, the administration has proposed that a cap be placed on the Federal share of medicaid.

The committee heard testimony on medicaid yesterday, but I believe this is an important part of what we are here to talk about today.

It has been my impression that the combination of the repeal of title V and medicaid cap would not be good for mothers and children.

One of the areas that I would like to have us explore here today are the issues raised by that particular approach.

We have a full morning ahead of us and I want to remind the witnesses that we will be very strict on our time limit for oral presentation. Your full statement in every case will be made a part of the record.

Our first witness, a gentleman who has been before us before on this health issue is Greg Ahart, Director of the Human Resources Division of the U.S. General Accounting Office.

All right, Greg, would you proceed with your statement?

TESTIMONY OF GREG AHART, DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C., ACCOMPANIED BY BERNARD UNGAR, SENIOR EVALUATOR, HUMAN RESOURCES DIVISION; THOMAS DOWDAL, GROUP DIRECTOR, HUMAN RESOURCES DIVISION; CARL MAYS, ATLANTA REGIONAL OFFICE

Mr. AHART. Thank you, Mr. Chairman. I am pleased to be here this morning.

I would like to introduce my associates. On my right, Mr. Bernard Ungar of my staff; Mr. Carl Mays from our Atlanta Regional Office, and on my left is Mr. Tom Dowdal of the Human Resources Division, who has the responsibility for our work in medicaid.

We are pleased to be here today to discuss the need to improve the maternal and child health program and to consolidate and better coordinate like and similar programs aimed at mothers, infants, and children.

Also, we would like to offer our observations on the administration's proposal to consolidate several categorical health programs, including those related to maternal and child health in the block grants to the States.

On a separate, but related matter, which you have mentioned, we have been asked to present our views on the administration's proposal for the medicaid cap, including modification of Federal requirements to provide more State flexibility in that program.

Some of the details in that proposal are vague, but our initial analysis indicates that you can make arguments on both sides of that issue.

With respect to the increased flexibility, we are in the process of developing an inventory of where State attempts to introduce cost-saving initiatives have been blocked by present Federal requirements.

We will provide this material to the committee, hopefully, within the next week or two.

Getting back to maternal and child health, during the past several years, we have issued several reports on Federal programs providing health and health-related services to mothers, infants, and children.

Today, we would like to focus on our report of January 21, 1980 on improving Federal efforts to reduce infant mortality.

That report contained several recommendations to the Congress and to the Department, many of which are supportive of the concept of block grants.

Skipping over to page 5 of my statement, two of our major findings prompted these and other recommendations.

First was the fragmented and unwieldy mechanisms of care for mothers, infants, and children that evolved over the years as related, but separate Federal programs were established.

Second was the inability of the maternal and child health program at the Federal and State levels to deal with this fragmentation.

As a result, persons living in many areas did not have ready access to health or related services, while some areas had a variety of federally funded health care services.

Also, pregnant women and infants, in some areas, received supplemental food, but did not receive health services, while in other areas the converse was true.

Efforts between public and private health care sectors were often not coordinated or were duplicated and health planning activities affecting mothers and infants were fragmented, uncoordinated, or duplicated.

The State maternal and child health agencies have generally been unable to overcome the problems resulting from this fragmentation, and there are several reasons for that.

The maternal and child health legislation provides the States strive to extend services to improve pregnancy outcome for mothers and infants statewide. However, States have been unable to extend such services to all people in need. In addition to limited funding, contributing factors were the variety of activities that compete for the use of maternal and child health funds and Federal requirements that States continue to fund a series of activities referred to as a program of projects in each of five areas: Maternity and infant care, infant intensive care, family planning, health services for children and youth, and dental health for children.

Although States do use a substantial portion of their maternal and child health funds for the program of project activities, these projects tend to serve relatively few communities.

We believe that the Congress needs to reassess the way in which maternal and child health funds are to be used in view of the other programs that have emerged.

We also believe that State agencies should develop comprehensive plans for using the maternal and child health funds.

The authorizing legislation and the Department regulations provide the State agencies are to plan, coordinate and promote maternal and child health care services and serve as a focal point for developing and implementing comprehensive statewide or regional systems of care for mothers and infants.

For the most part, State agencies have not fulfilled this intended role. One of the major reasons for this inability has been that the Department bypasses the State agencies and awards project grants directly to private organizations as authorized by law under a number of programs.

We think it is unrealistic to expect them to serve as an effective focal point without some input into these kinds of projects.

A more fundamental problem has been the lack of commitment and attention by the Department during much of the 1970's to meeting the objectives of the maternal and child health program.

Turning now to the administration's proposals, I would like to point out that our comments are based on our quick analysis of preliminary proposals, but we will be pleased to provide the committee with additional comments after those proposals have been firmed up in final form.

We endorse the concepts underlying the administration's proposals. Our recent report on infant mortality and sudden infant death syndrome and several other GAO reports illustrate the need for action along the lines intended.

We have not sufficient time to fully evaluate the proposals, but we do have several observations and comments that we believe

that the Congress needs to consider. They relate primarily to the need to group maternal and child health programs together in the same block grant, the relationship between programs designated for health block grants and other programs, and lessons that should be learned from previous consolidation efforts, including the need for accountability at Federal and State levels.

On page 11 of my statement, Mr. Chairman, I note that the administration proposes to place several programs which generally address the objectives of title V of the Social Security Act into three different block grants rather than one, and I have listed those there under the health services health grant that include maternal and child health programs that address hemophilia, sudden infant death syndrome and supplemental security income as it relates to disabled children.

In the preventive health services block grant, they would include family planning, genetic diseases, lead-based paint poisoning and adolescent health services.

And under the social services block grant, they would include the program for developmental disabilities well as the family planning component of the social services program under title XX of the Social Security Act.

We believe that the Congress and the administration need to consider whether these programs should be grouped under the same block grant.

They generally meet the criteria which has been set forth by the Advisory Commission on Intergovernmental Relations for identifying the most likely candidates for consolidation.

And consistent with these criteria, you can make several arguments for consolidating the programs that are addressed and are aimed at meeting the objectives of title V.

First, they are aimed at the same target population and at the same overall objectives.

Second, the Federal Government has had a special interest in and focus on mothers, infants, and children since 1912.

Third, the structure of the maternal and child health program already provides a basis for a block grant program.

And, fourth, the States already have administrative units to plan, coordinate, manage and evaluate State-based maternal and child health programs.

Now, there is need for some improvement in the way they carry out these functions, but we believe that can be done.

Block grant proposals that we have seen contain little information on the relationship of the block grants to other programs, such as the supplemental food program for women, infants, and children administered by the Department of Agriculture. The early and periodic screening, diagnosis, and treatment program under medicaid, or the education for all handicapped children program.

These are closely related to the health programs slated for the block grants, particularly the maternal and child health program, and our work has identified a need for closer ties between the WIC program, that is a supplemental food program, and the health programs in a number of areas. Also, we believe that the consolidation of at least the outreach and screening components of the early and periodic screening, diagnosis, and treatment program of medic-

aid and the maternal and child health program, or a block of such programs, should enhance the effectiveness of both.

Turning now to the lessons that have been learned from GAO reviews, we've completed many during the last several years on previous program consolidations, or the programs which are slated for inclusion in the block grants.

These have identified problems and cautions which we believe the Congress should consider in its deliberation on the administration's proposals.

First, conversion of the Federal categorical programs in the block grants may not always result in improved program management and funding allocations that better match needs and resources.

Second, in our opinion, block grant programs must include provisions for insuring accountability for proper use of Federal funds, achieving broad national objectives and priorities, and prohibiting the substitution of Federal funds for State funds.

Third, the current funding allocations may not reflect the need or demand for services. We note that the administration proposes that the allocations under the block grants will be proportional to the allocations presently under the programs that would be consolidated.

That might not be a good match with the actual need, particularly because some programs now bypass the State agencies.

Fourth, the States will need sufficient time to prepare for administering those aspects of block grants that they currently are not involved in. Again, these include programs that have bypassed the State agencies traditionally.

Fifth, and, finally, there is a need for a uniform definition of what low income means. The administration's proposals are aimed particularly at helping low income persons.

The Congress should specifiy a uniform definition of these persons applicable to the three different block grants. Lack of such a definition has resulted in inconsistencies and inequities among persons receiving family planning services under maternal and child health, under the title X family planning program, and under the title XX social services program.

In summary, Mr. Chairman, we believe that the Congress will need to provide for a special focus on maternal and child health accountability requirements if it wants to assure that the objectives of title V of the Social Security Act are effectively and efficiently met.

This concludes the summary of my statement, Mr. Chairman.

I might note that we have appended to our statement a list of GAO reports that the committee might find useful, as well as some reports produced by others that might be useful in considering the administration's proposals.

Senator DURENBERGER. Thank you, Mr. Ahart, and thank you for the completeness of your report.

I thank you also for the historical perspective that you put this issue into.

I have just one main question to address to you, I guess, based on that kind of perspective that you have put this in. One of the other things the administration is doing as they make recommendations

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to us with regard to our present decisions regarding past programs speaks to the issue of competition and health care.

They speak to it in the near term rather than in long term, which I, as a champion of competition, believe is more appropriate. But if you buy the competition theory, you also have to buy the idea that the ultimate in competition is consumer choice. That what we are about here is overcoming the greatest liability to quality health care in this country which is an ill-informed consumer of health care and you would also then have to buy the theory that as consumer choice develops, there is an automatic accent on prevention and wellness and a lot of these things that much of maternal and child health is aimed at.

And you might also then have to buy the theory that our role here at the national level is to make sure that nobody is deprived of access to this system of wellness, prevention, health care delivery, that they have adequate information on which to base their choices and that they have a sense of income security so that regardless of where they come from in our economic or social system, they are not going to be deprived of access to the system by reason of lack of income.

So, it seems to me that as we move down the line here, we are not only talking about devolving more responsibility from a wide ranging national categorical system that has a financial answer for single health care in the country, and devolving some of that into blocks and putting more responsibility out there with the States. We are talking about an ideal system in which individuals are making choices and Government is merely providing opportunities, but not necessarily directly financing the delivery of those services.

So, having said that, I get to something that has been bothering some of us, I think, on this committee. The idea of taking title V out of the Social Security Act, which is primarily aimed at the income security issue, and where it has been since 1935, and sending it over someplace else into a categorical—consolidated categorical or block grant process, seems to be going in exactly the opposite direction from which we should be going.

So, I would be curious to know your observations with regard to the role that the Social Security Act, title V, and the other appropriate titles should play in the future of maternal and child health care.

Mr. AHART. I think I might apologize. As I went through my statement, I think I said title V of the Public Health Service Act. You are right, it is the Social Security Act.

On your general question, it seems to us that the mechanism of the title V administrative structure and Federal-State cooperative relationships have been in place for quite a long period of time to operate the programs that have been sponsored and authorized under title V.

It would seem to us that there needs to be a very good reason for disturbing the existing structure rather than building on where we're at. We think that based on our work, and particularly our 1975 report, which you will see referenced in the appendix to my statement.

We found that even though there was a lot of flexibility, the States were not going a good job of marshalling the resources made

available to meet the needs. In that context, we think there is a need to revitalize that program and make sure that States are utilizing flexibility that's made available to better articulate the resources against the needs of the people that they serve.

This can be done, to some degree, by perhaps removing some of the restrictions from title V, particularly the one that calls for a program of projects which tends to concentrate resources in particular areas of the State rather than trying to meet needs on a broader basis.

It can be done also by perhaps folding into title V some of the funds that are now available under other authorities, such as for family planning, sudden infant death syndrome, and other programs. Such a consolidation would enable States to put resources together in the context of a comprehensive plan that is well developed, and based on the assessed needs. Also, it could give them more resources to better articulate against those needs and better meet the needs of the people that they are trying to serve, keeping in mind what you talked about relative to patient choice.

I think a lot of the people that we are talking about servicing under these programs—the target populations—are people that by necessity seek services from the public sector and that is at least their entrance point into the health care delivery system. And I think for you and I, and for all of us, we have some entry point whether it be the family doctor, or whether it be the outpatient clinic at the hospital, or whether it be a community health center, or whatever. Once we have made a choice of that entrance point, depending on what our means are and what options we have and what financing is available, from that point on, I think, we are all kind of captives of whatever is in the system. This is because most of us tend to do and go to the next place that our doctor tells us to go to because we have to put a lot of faith and trust into the judgment of those professional providers who we contact at the entry point.

That kind of gets to your overall statement on competition. I think competition really, for the most part, goes to where you enter the system rather than to what happens to you once you've entered it, because, I think, at that point necessarily, the health professionals pretty much take control of what happens to you and, hopefully, in the best interest of the person involved.

I don't know, that's a rather long answer to your long statement and your short question, but it is a very difficult thing to deal with, I think. I think there are a lot of things that the Congress has to consider in trying to deal with the polemic, if you will, of the administration's proposal—trying to structure the resources that will be available and the best way to meet the needs of the target populations we are trying to serve.

Senator DURENBERGER. I think we take either blocking or consolidation for granted, I mean, as part of change in the system and in your testimony, and that of others is helpful in telling us what to consolidate or what to block, but then the second issue is that one that I have just addressed and that is: what is the legalistic mechanism, I guess, or the policy mechanism that is most appropriate to the future, and I appreciate your comments.

Senator Byrd.

Senator BYRD. I take it from your comments you feel that the administration, generally speaking, is on the right track?

Mr. AHART. That's correct, Senator. I think for a lot of years we have been impressed with the great deal of fragmentation that there is in the structure of Federal assistance to States and localities in providing all kinds of different services. As a general proposition, we would favor consolidation. There are a lot of different ways the pie can be cut. There are a lot of different ways it can be packaged. There are different mechanisms through which they have been made available, but certainly to go the direction of reducing the number of authorities and giving flexibility to the people that have to deliver the services, but with whatever strings—the accountability strings—that the Congress deems should be in place to make sure that those funds are serving the national priorities that the Congress had in mind.

We think that is the proper direction to move in.

Senatory BYRD. Very good. Thank you.

Senator DURENBERGER. Thank you very much, Mr. Ahart, we appreciate your testimony.

[Statement follows:]

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION

Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss the need to improve the Maternal and Child Health (MCH) program and to consolidate and better coordinate like or similar programs aimed at mothers, infants, and children. Also, we would like to offer our observations on the Administration's proposals to consolidate several categorical health programs, including those related to maternal and child health, into block grants to the States.

Further, on a separate but related matter, we have been asked to present our views on the Administration's proposal to limit or "cap" Federal contributions to State operated Medicaid programs and, at the same time, to modify Federal requirements to provide States with more flexibility in managing programs. Although some of the details of the proposal are vague, our initial analysis indicates that valid arguments have been made on both sides of this issue.

With respect to possible modifications to existing Federal requirements, we are currently developing an inventory of instances over the past 5 years where States have attempted to introduce cost-saving initiatives to their programs but where such efforts have been blocked as being inconsistent with Federal requirements. We plan to provide this material to the Committee.

Getting back to Maternal and Child Health, during the past several years, we have issued several reports on Federal programs providing health and health-related services to mothers, infants, and children. Today, we would like to discuss a number of these reports, but focus on our January 21, 1980, report to the Congress on improving Federal efforts to reduce infant mortality.

Reducing infant mortality, promoting the health of mothers and children, and locating and treating crippled children or children who suffer from conditions leading to crippling are the major objectives of the Maternal and Child Health program authorized by title V of the Social Security Act. With fiscal year 1980 funding of over $375 million, MCH is the major Federal health program aimed specifically at mothers, infants, and children and at reducing infant mortality.

RECOMMENDATIONS FOR IMPROVING FEDERAL AND STATE EFFORTS

Our January report contained several recommendations to the Congress and to the Department of Health and Human Services (HHS) aimed at achieving (1) a more organized and systematic effort at Federal, State, and local levels, (2) greater flexibility at the State and local levels to match resources with needs, (3) better cooperation between public and private health care sectors, (4) more accountability for use of Federal funds, and (5) better program monitoring and evaluation. Many of our recommendations are supportive of the concept of block grants and should be useful to the Congress in considering the Administration's proposals.

For example, our major recommendations to the Congress were:

1. Over the long run consolidate Federal programs funding similar types of activities, directed principally toward health care for women, infants, or children, into one MCH program. We identified the MCH, Family Planning, Adolescent Pregnancy, Sudden Infant Death Syndrome, and genetic disease screening and counseling programs as candidates for such a consolidation. Our recently completed review of the Sudden Infant Death Syndrome program reaffirmed our view that this program should be consolidated with the MCH program, and our February 6, 1981, report recommended that the Congress direct such a consolidation.

2. In those cases where consolidation is not feasible or might take a long time to accomplish, require the administering agencies at the Federal, State, and local levels to coordinate their activities. We specifically identified the Special Supplemental Food Program for Women, Infants, and Children (WIC) as falling into this category.

3. Revitalize the MCH program by: strengthening the management role and ability of State MCH agencies; giving States more flexibility consistent with national policy, goals, or guidelines in using MCH funds; and directing HHS to monitor more closely MCH activities and use of funds and to take corrective action when State MCH agencies are not complying with requirements or making satisfactory progress toward achieving program goals.

Similarly, our recommendations to HHS for improving its and the States' management of maternal and child health efforts are also generally in-line with the block grant concept. They do, however, call for somewhat more accountability and Federal oversight than the Administration's proposals envision. Nonetheless, we believe that this is not inconsistent with the notion of giving States more latitude and flexibility in using Federal funds to meet broad national objectives for reducing infant mortality and improving the health of mothers and children.

We recommended, in part, that HHS:

Designate someone to be responsible for coordinating its various programs related to maternal and child health;

Formulate national goals in the maternal and child health area;

More systematically use categorical programs to help States match available Federal resources with unmet need in accordance with State priorities; and

More closely monitor State progress in meeting national objectives, giving assistance to those States not progressing satisfactorily.

At the State level, we believe a comprehensive, multiyear, statewide maternal and child health plan is needed. The purpose of such a plan would not be to satisfy a Federal requirement, but would be to stimulate the development of a working document that could be used to allocate funds and measure progress. Also, we believe that the States should be more aggressive in promoting the concept of regionalized perinatal care. This concept is aimed at improving the quality and reducing the cost of medical care by providing the most appropriate level of care to mothers and infants.

Two of our major findings prompted these and other recommendations. First was the fragmented and unwieldy mechanisms of care for mothers, infants, and children that evolved over the years as related but separate Federal programs were established. Second was the inability of the MCH program at the Federal and State levels to deal with this fragmentation.

NEED FOR A BETTER PLANNED, MORE SYSTEMATIC APPROACH

Since establishing the MCH program in 1935, many other programs have been created that provide access to the same or related types of services or activities funded by MCH. These programs include, but are not limited to, Medicaid, including Early and Periodic Screening, Diagnosis, and Treatment; Community Health Centers; National Health Service Corps; Family Planning; and Special Supplemental Food. For the most part, these programs have been administered independently and frequently without coordination with the MCH program at the Federal, State, or local levels.

Some of the consequences of this fragmentation were:

Persons living in many areas did not have ready access to or had difficulty obtaining health or related services that could help reduce infant mortality, while some areas had a variety of federally funded health care services.

Pregnant women and infants in some areas received supplemental food under the WIC program but did not receive health care services, and persons in other areas received health care services but not supplemental foods even though WIC's authorizing legislation requires WIC and health care services to be linked.

Efforts between the public and private health care sectors were often not coordinated or were duplicated.

Health planning activities affecting mothers and infants were fragmented, not coordinated, or duplicated.

State MCH agencies have generally been unable to overcome the problems resulting from this fragmentation for several reasons, including restrictive Federal requirements and lack of commitment or support at the Federal and State levels.

MCH PROGRAM HAS NOT MET EXPECTATIONS

Historically, MCH funds have enabled States to extend health services to women, infants, and children in urban and rural areas and to improve the mangement and promotion of MCH activities. However, MCH funds have not been sufficient to enable States to extend services to all those in need or to extend services to the extent envisioned in authorizing legislation or program regulations. In addition, State MCH agencies have had only limited effectiveness in their intended role as a planner, coordinator, overseer, evaluator, or focal point for MCH activities.

Use of MCH funding needs reassessment

MCH authorizing legislation provides that States strive to extend services to improve pregnancy outcome for mothers and infants statewide. However, States have been unable to extend such services to all areas or to all women and infants in need. In addition to limited funding, the factors that have contributed to this situation were (1) the variety of activities that compete for use of MCH funds (such as in-hospital care for mothers, infants, or children, well-baby care, prenatal care, dental care, and family planning) and (2) Federal requirements that States—using MCH funds—continue to fund a series of activities referred to as the "program of projects."

States must have a program of projects in each of five areas—maternity and infant care, infant intensive care, family planning, health services for children and youth, and dental health for children. Although States use a substantial portion—about 54 percent—of their Federal MCH formula grant funds for program of project activities, these projects serve relatively few communities. For example, 30 States reported having only one maternity and infant care project and, in the aggregate, States report that maternity and infant care projects serve only about 240 of the 3,100 counties in the Nation.

We believe that the Congress needs to reassess the way MCH funds are to be used, including the program of projects concept, in view of the other programs that have emerged. We believe that State MCH agencies should develop comprehensive plans for improving pregnancy outcome and using MCH funds. These plans should:

Identify and prioritize unmet needs;

Identify available resources, including other Federal project grant programs, and the ability or inability of these resources to meet unmet needs; and

Describe how MCH funds will be used to fill gaps which cannot be met through other programs because of insufficient funds, lack of an area's eligibility for such programs, or other reasons.

MCH management needs improvement

MCH authorizing legislation and/or HHS regulations provide that State MCH agencies are to plan, coordinate, and promote maternal and infant care services and serve as a focal point for developing and implementing comprehensive statewide or regional systems of care for mothers and infants. For the most part, State MCH agencies have not fulfilled their intended role as a focal point for improved management of MCH activities. This has contributed to slow progress in developing and implementing comprehensive statewide or regional systems of care for mothers and infants. For example, none of the States we visited had current, comprehensive, or action-oriented plans for reducing infant mortality.

State MCH agencies in some cases have not served or have not been able to serve as a focal point for improving pregnancy outcome for several reasons. These include their failure to have assumed or been given this role in their States, their heavy emphasis on service delivery, and the little emphasis given to the MCH program by HHS for several years.

One of the major reasons State agencies have been unable to serve as a focal point is that HHS bypasses State MCH agencies and awards project grants directly to private organizations. State MCH agencies we visited usually had little or no information on or influence over project grants—such as for Community Health Centers—made by HHS directly to local organizations. It is unrealistic to expect State MCH agencies to plan, develop, or promote an integrated system of care for mothers, infants, and children without some input into the planning, placement, and operation of such projects.

An even more fundamental problem, however, has been the lack of commitment and attention by HHS during much of the 1970s to meeting the objectives of the MCH program. The need for better management, including improved planning, of maternal and child health activities at the Federal and State levels was stressed by representatives from several organizations in connection with June 30, 1980, oversight hearings by the Subcommittee on Child and Human Development, Senate Committee on Labor and Human Resources. These organizations included the American Academy of Pediatrics, the American Association of State and Territorial Health Officers, and the March of Dimes Birth Defects Foundation.

COMMENTS ON BLOCK GRANT PROPOSALS

Our testimony today is based on our quick analysis of the preliminary Administration proposals for repealing title V and creating block grants. We will be pleased to provide the Committee with additional comments after we have had a chance to more fully evaluate the Administration's final proposals.

We endorse the concepts of (1) consolidating separate categorical programs having related objectives and serving similar target populations, (2) placing management responsibility for similar programs in the same agency, (3) giving the States greater flexibility to match resources with needs and priorities, and (4) resolving the problems frequently created when Federal project grants are awarded directly to local organizations, bypassing relevant State agencies. Our recent reports on infant mortality and Sudden Infant Death Syndrome clearly illustrate the need for these actions as do several other GAO reports, such as our January 1977 report on Federal efforts to help mentally disabled persons return to communities from institutions.

While we have not had sufficient time to fully evaluate the Administration's specific proposals for establishing block grants, we have several observations and comments that we believe the Congress needs to consider in its deliberations. These relate primarily to (1) the need to group MCH programs together in the same block grant, (2) the relationship between programs designated for health block grants and other programs, and (3) lessons that should be learned from previous consolidation efforts, including the need for accountability at the Federal and State levels.

Need to group MCH programs together

The Administration proposes to place several of the programs which generally address the objectives of title V into three block grants to the States rather than one. These are:

Health service: MCH hemophilia, sudden infant death syndrome, and supplemental security income/disabled children.

Preventive health service: family planning, genetic diseases, lead-based paint poisoning prevention, and adolescent health services.

Social services: Developmental disabilities.

The Congress and the Administration need to consider whether these HHS programs should be grouped into the same block grant.

These programs generally meet the criteria set forth by the Advisory Commission on Intergovernmental Relations [1] for identifying the most likely candidates for consolidation. According to the Commission, programs to be merged should be, or be capable of being made:

Closely related in terms of the functional area covered;

Similar or identical with regard to their program objectives; and

Linked to the same type of recipient governmental jurisdictions.

Several arguments can be made for consolidating programs addressing the objectives of title V. These arguments are generally consistent with the Commission's criteria set forth above as well as other criteria, such as strong and continuous congressional support, established by the Commission for the design and use of block grants.

First, these programs are generally aimed at the same target population and at the overall objectives of reducing infant mortality or morbidity, improving the health of mothers, infants, and children, or locating and treating crippled children. Separation of these programs has led to fragmentation of effort at Federal and State levels and has seriously impaired the ability of Federal and State agencies to develop and administer well-planned and organized efforts. These problems have been amply demonstrated in our October 1977 report on Federal and State efforts to

[1] A national bipartisan organization representing the executive and legislative branches of Federal, State, and local government and the public. It was created by the Congress to monitor the operation of the Federal system and to recommend improvements.

prevent mental retardation and, again, our January 1980 report on Federal and State efforts to reduce infant mortality.

Second, the Federal Government has had a special interest in and focus on health care for mothers, infants, and children since 1912. This focus and interest developed because of particular problems these group had, especially in low-income and rural areas, gaining access to health care and because of the variety of needs and organizations involved, including educational, health, nutritional, social services, and welfare. Although much progress has been made in reducing infant mortality and improving the health of mothers and children, these groups continue to experience access to care problems. Efforts to deal with these problems continue to be disorganized and fragmented among different programs and organizations.

Third, the structure of the MCH program already provides the basis for a block grant program. The bulk of MCH funding is distributed to the States through a formula grant. With some exceptions, it appears that the activities carried out under these separate programs are already authorized by the title V formula grant program. Accordingly, the authorizing legislation for these programs could lapse and funding could be transferred to title V. Also, title V could be modified to eliminate those provisions which are considered too restrictive, such as the program of projects requirements, and to authorize any additional activities the Congress believes are desirable.

Fourth, States already have administrative units to plan, coordinate, manage, and evaluate State-based maternal and child health programs. Although these units have varied in the degree to which they have fulfilled their responsibilities, their capacities could be improved and they could either assume additional responsibilities for other programs or be merged into a larger organizational unit having responsibilities for basic health services. In several cases, State MCH agencies already administer several different Federal programs in the maternal and child health area, such as MCH, Sudden Infant Death Syndrome, Family Planning, Genetic Diseases, WIC, and Early and Periodic Screening, Diagnosis, and Treatment.

Relationship between programs designated for health block grants and other programs

The block grant proposals we have seen contain little information on the relationship of the block grants to other programs, such as WIC, Early and Periodic Screening, Diagnosis, and Treatment under Medicaid, or Education for All Handicapped Children. These are closely related to the health programs slated for the block grants, particularly the MCH program. Both our January 1980 report on infant mortality and our February 1979 report on the WIC program identify the need for closer ties between WIC and health programs in a number of areas.

The December 1980 report of the Select Panel for the Promotion of Child Health, "Better Health for Our Children: A National Strategy," reaffirms the problems identified in our January 1975 report on Early and Periodic Screening, Diagnosis, and Treatment. We and the Panel reported on the failure of the program to reach a large segment of the target population. Major impediments to accomplishing program objectives have been the lack of organized, aggressive efforts to reach, screen, and followup on eligible children and lack of participation by physicians because of low Medicaid reimbursement rates or other factors.

Consolidation of at least the outreach and screening components of Early and Periodic Screening, Diagnosis, and Treatment and the MCH program, or a block of MCH programs, should enhance the effectiveness of both. Health departments have traditionally sponsored child screening programs. The additional funding and impetus of such a consolidation should put them in a position to improve and enlarge their efforts.

Lessons learned from previous GAO reviews

Many GAO reviews completed during the last several years on previous program consolidations or the programs slated for inclusion in block grants identified problems or cautions which we believe the Congress should consider in its deliberations on the Administration's block grant proposals. Some of these are that:

All expected benefits may not materialize;

Provisions for accountability are necessary;

The proposed funding allocation formula may not accurately reflect need;

States will need time to prepare for block grants; and

A uniform definition of low-income among the health and social service blocks may be desirable.

Following is a discussion of these.

All expected benefits may not materialize

Conversion of Federal categorical programs into block grants may not always result in improved program management and funding allocations that better match needs and resources. For example, in our December 1975 report on how States plan and use formula grant funds for maternal and child health and comprehensive public health services (section 314(d) of the Public Health Service Act which consolidated 16 categorical programs), we stated that the three States we studied had neither established adequate planning procedures to identify needs nor gathered sufficient data to establish priorities or measure program results. Also, the health services provided were fragmented and not well-managed. The same activities were continued each year, with little management review, while major unmet needs existed in many areas. Similar problems were reported in our January 1980 report on efforts to reduce infant mortality.

Need for accountability

Our studies have repeatedly shown that lack of focus and emphasis on maternal and child health at the Federal and State levels has resulted in diminished efforts; ineffectiveness; lack of meaningful planning, needs assessments, prioritization, coordination, and change; or lack of accountability. In our opinion, block grant programs must include provisions for ensuring accountability for proper use of Federal funds, achieving broad national objectives and priorities, and prohibiting substitution of Federal funds for State funds. We believe that such provisions are consistent with and should enhance the Administration's goals of (1) improving health service delivery effectiveness, (2) giving States greater control over resources, and (3) making more efficient use of resources.

Some of the accountability provisions we recommend are:

Clearly stated Federal objectives and priorities, phrased in a manner so that results can be objectively measured.

Preparation of a State plan setting forth needs, priorities, objectives, and intended use of funds.

Periodic financial management monitoring and programmatic evaluation. Audit requirements should be in accordance with Office of Management and Budget circulars and "Standards For Audit of Governmental Organizations, Programs, Activities, & Functions."

Reasonable State reporting on use of funds and accomplishment of Federal and State objectives.

Maintenance of effort requirements with waiver authority to allow for bona fide State spending reductions.

Again, these provisions are consistent with the design features suggested by the Advisory Commission on Intergovernmental Relations for developing block grant legislation.

Current funding allocation may not reflect need or demand for services

The Advisory Commission on Intergovernmental Relations recommends that block grant funding be distributed to the States based on need. We understand that the Administration, after considering several alternatives, plans to allocate block grant funds based on the amount of funding currently being given to each State under the programs slated for block grants. However, current funding allocations may not accurately reflect need, particularly with respect to project grant programs, such as Community Health Centers or Family Planning.

For example, Federal funds for Community Health Centers generally bypass State agencies and are awarded to private local organizations. Our recently completed review of this program, as well as some of the other programs proposed for consolidation, showed major problems in the mechanisms used to determine the need for program funds and location of projects.

In our view, States will need sufficient time to evaluate their needs and priorities in relation to the projects funded by HHS.

States need time to gear-up for block grants

States will need sufficient time to prepare for administering those aspects of block grants that they currently are not involved in. For example, our June 1972 report on the conversion of the MCH project grant program to formula grants pointed out that it took several years for the States to plan and prepare for the conversion.

Consolidating programs currently administered by State MCH agencies should not pose major startup problems for most States. However, transferring other programs to State control that HHS currently administers as project grants may be a different story. States will probably need sufficient time to prepare for administering funds from such project grant programs as Community Health Centers and Migrant

Health. This is particularly true in view of our findings that current funding allocations in the former program may not reflect need.

Need for uniform definition of low income

The Administration's proposals for health, preventive health, and social services are aimed particularly at helping low-income persons. The Congress should specify a uniform definition of low-income persons applicable to the three different block grants. Lack of such a definition has resulted in inconsistencies and inequities among persons receiving family planning services under the MCH, title X Family Planning, and title XX Social Services programs. MCH and title XX Social Services programs permit, but do not require, collection of fees from persons with the ability to pay, while title X requires collection of fees from persons who are not from low-income families. These programs do not use the same definition of low-income families. Each program is designated to be included in a separate block grant under the Administration's proposals.

In summary, we believe that the Congress will need to provide for a special focus on maternal and child health and accountability requirements if it wants to ensure that the objectives of title V are effectively and efficiently met nationwide under block grants. This concludes our statement. Mr. Chairman, we would be pleased to answer any questions you or other Members of the Committee may have.

SELECTED GAO AND OTHER REPORTS THAT MAY BE USEFUL TO THE COMMITTEE

GAO reports

"Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome," (HRD-80-24, Jan. 21, 1980).

"The Sudden Infant Death Syndrome Program Helps Families But Needs Improvement," (HRD-81-25, Feb. 6, 1981).

"Evaluating Benefits and Risks of Obstetric Practices—More Coordinated Federal and Private Efforts Needed," (HRD-79-85, Sept. 24, 1979).

Letter Report to the Director, Department of Human Resources, Government of the District of Columbia, on infant mortality problems in the District (Oct. 31, 1978).

"The Special Supplemental Food Program for Women, Infants, and Children (WIC)—How Can It Work Better?" (CED-79-55, Feb. 27, 1979).

"Preventing Mental Retardation—More Can Be Done," (HRD-77-37, Oct. 3, 1977).

"How Federal Developmental Disabilities Programs Are Working," (HRD-80-43, Feb. 20, 1980).

"HUD Not Fulfilling Responsibility to Eliminate Lead-Based Paint Hazard in Federal Housing," (CED-81-31, Dec. 16, 1980).

"State Programs For Delivering Title XX Social Services to Supplemental Security Income Beneficiaries Can Be Improved," (HRD-79-59, Apr. 11, 1979).

Federal Assistance System Should Be Changed to Permit Greater Involvement By State legislatures," (GGD-81-3, Dec. 15, 1980).

"Proposed Changes in Federal Matching and Maintenance of Effort Requirements for State and Local Governments," (GGD-81-7, Dec. 23, 1980).

"Returning the Mentally Disabled to the Community: Government Needs To Do More," (HRD-76-152, Jan. 7, 1977).

"Administration of Federal Assistance Programs—A Case Study Showing Need for Additional Improvements," (HRD-76-91, July 28, 1976).

"How States Plan For And Use Federal Formula Grant Funds to Provide Health Services," (MWD-75-85, Dec. 9, 1975).

"Fundamental Changes Are Needed in Federal Assistance To State And Local Government," (GGD-75-75, Aug. 19, 1975).

"Improvements Needed to Speed Implementation of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program," (MWD-75-13, Jan. 9, 1975).

"Review of Selected Communicable Disease Control Efforts," (B-164031 (2), June 10, 1974).

"Maternal and Child Health Programs Authorized by Title V, Social Security Act," (B-164031 (3), June 23, 1972).

Other reports

"Better Health For Our Children: A National Strategy, The Report of the Select Panel for the Promotion of Child Health: 1980" (DHHS (PHS) Publication No. 79-55071).

"Hearing Before the Subcommittee on Child and Human Development of the Committee on Labor and Human Resources, U.S. Senate, Oversight on Efforts to Reduce Infant Mortality and to Improve Pregnancy Outcome," June 30, 1980.

"Summary and Concluding Observations, The Intergovernmental Grant System: An Assessment and Proposed Policies," Advisory Commission on Intergovernmental Relations, June 1978.

Senator DURENBERGER. Our next witnesses are a panel of two—Dr. Herbert J. Cohen, president of the American Association of University Affiliated Programs for the Developmentally Disabled; vice chairman of the President's Committee on Mental Retardation; director, University Affiliated Facility at the Albert Einstein College of Medicine, New York, and Pat Klauck, association chairman and executive director, Minneapolis Children's Health Center, Minneapolis, Minn., on behalf of the National Association of Children's Hospitals and Related Institutions, Inc.

Welcome both of you and we appreciate the opportunity to have you share with us your thoughts on a subject that I know concerns you as much, or more than it does us.

Dr. Cohen, are you going first?

Dr. COHEN. Yes; thank you.

STATEMENTS OF HERBERT J. COHEN, M.D., PRESIDENT, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS FOR THE DEVELOPMENTALLY DISABLED; VICE CHAIRMAN, PRESIDENT'S COMMITTEE ON MENTAL RETARDATION; DIRECTOR, UNIVERSITY AFFILIATED FACILITY AT THE ALBERT EINSTEIN COLLEGE OF MEDICINE, NEW YORK, N.Y.; PATRICIA KLAUCK, ASSOCIATION CHAIRMAN AND EXECUTIVE DIRECTOR, MINNEAPOLIS CHILDREN'S HEALTH CENTER, MINNEAPOLIS, MINN., ON BEHALF OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC.

Dr. COHEN. Good morning, Mr. Chairman.

The Association of University Affiliated Programs is a 16-year-old national network, 47 university-based programs in 34 States. Our principal purpose is to train personnel who will provide services to the mentally retarded, developmentally disabled, particularly the more severely handicapped children.

People who are trained, work and are still unquestionably needed to man a $12 billion national program for the mentally retarded, developmentally disabled. That program is supported by $5 billion in Federal funds, of which the training component is a very small one.

The UAP's develop model service programs to serve the developmentally disabled and we are very out front in applying the latest technology in terms of helping the States in their maternal and child health effort and work with crippled children.

We work closely with the directors of those programs in States and train personnel and provide a deep needed technical assistance.

We are also very key tertiary care providers, Mr. Chairman, and we ourselves provide 68,000 direct services to severely handicapped children. My own program, we provide about 5,000 services to children with very difficult and complex problems who under the competitive system often do not have access services except those that are supported by centers such as ours.

UAP's have been integral to the national effort working in the field of mentally retardation, developmental disability over the last 16 years working with the Federal Government, regions and States.

I might say that the previous speaker mentioned something about special projects, and we have been involved with quite a number of special projects over the year, and I think one has to clarify what the impact of those are.

In our written testimony, we mention something about PKU as an example. Through a special project that was given, and through a number of other special projects, there have been a national collaborative effort to combat phenylketonuria. A simple screening test was developed which costs pennies and now is extended to screen for a variety of metabolic disorders developed through that national effort so that these special projects have had tremendous impact in assisting the States, as well as regions. In fact, some of our facilities actually provide genetic and metabolic screening programs to regions, which, of course, is somewhat counter to the block grant concept.

We worked in integrating handicapped children into Headstart, and working with generic agencies in the kind of integration that the previous speaker was mentioning, because of the absence of it in the kinds of programs that now exist.

I would like to offer some data, Mr. Chairman, on the value and cost-effectiveness of some of these programs.

I can give you an example of our own home program, which serves 5,000 people in the Bronx. Over the last year, we have detected 20 cases of fetal alcoholism syndrome, a syndrome which was first discovered at one of our University Affiliated Centers at the University of Washington.

We have been able to realistically get 10 of those parents for help in combating the mother's alcoholism in family planning efforts so that we have literally prevented the birth of 10 subsequent children who would be mentally retarded with fetal alcoholism syndrome.

The lifetime care of those children would be a million and half dollars over their lifetime. We have made similar efforts in Down's syndrome. In the past year, I have identified two instances where we've prevented this problem from occurring.

Early intervention efforts also have a way of mitigating the effects of disability and saving long-term costs. This is one UAF, I'm mentioning, $250,000 maternal and child health investment with 70-fold return preventing a minimum conservatively of $18 million in long-term costs.

Mr. Chairman, we believe very strongly that dollar savings are very important in these days and consolidation of programs are as well.

We believe the kinds of efforts that these special projects that the University Affiliated Programs have contributed are very valuable ones to long-term effort in this country.

We believe that we are an important national resource and that we have provided a very critical effort to the mission of the country, as well as provided needed training so that others could go out and do similary as we do in providing services throughout the country.

We urge continuation of the title V program, a very valuable program as a strong nationally directed program with continuation of the essential research and training components, including the UAP's.

I thank you.

Senator DURENBERGER. Thank you very much.

Pat.

Ms. KLAUCK. Thank you, Mr. Chairman, for the privilege to present testimony on behalf of the National Association of Children's Hospitals.

Our association is composed of 73 children's hospitals. These hospitals admit 90 percent of the patients cared for in children's hospitals and provide over 2.5 million days of care per year, and experience about 4 million outpatient visits.

The annual expenditures on behalf of these children approach $1.3 billion. No small amount of money.

These hospitals are well represented by other organizations which can speak to their interests as hospitals. By their very existence they are advocates for children. We come to you today in that particular role.

We want to speak to three proposals contained in the program for economic recovery, that of title V, title XIX and the end stage renal disease program.

We have furnished a detailed written statement to the committee, and I will just highlight some of the points in that statement.

In regard to title V, the Federal role of coordination, stimulation, standard development and program assessment of the title V program has been integral to its success.

The Federal-State-local partnership which has resulted is its strength. Its incorporation into a block grant mechanism with unrelated programs will dilute its benefits to mothers and children and reduce its funding to a purchase of services mechanism.

The proposed reduction in its funding, which in recent years has not met the effects of inflation, reflects an unacceptable priority for the needs of mothers and children.

The proposal to limit title XIX medicaid funding to 105 percent of fiscal year 1981 expenditures, which in turn would be capped $100 million below the projected fiscal 1981 outlays is independent of the activities of many States which have already been planning to limit medicaid eligibility and scope of benefits.

We must face the fact that a cutback in medicaid eligibility or reduction in its benefits will not reduce children's needs for health care services.

To the extent possible, all children's hospitals will continue to serve patients who are in need, irrespective of their ability to pay.

I will refer subsequently to 30 hospitals. These hospitals provided $16.7 million in charity care last year. The children's hospitals, typically, are underfunded. We do not have a large cushion which we can fall back on to meet the costs of the charity services.

Endowments of these 30 children's hospitals averaged $2 million each.

These hospitals, of course, have an obligation to all children, including those who have been covered by medicaid.

As a consequence, essential, but nonemergent services to those who have no source for reimbursement may have to be curtailed.

To measure the effects of these cutbacks, we looked at data obtained from these 30 children's hospitals. It is interesting to note that in them, 35 percent of over 1 million inpatient days of care were provided to medicaid patients. Nineteen of these hospitals reported that 43 percent of their 727,000 outpatient visits were medicaid patients, as was 41 percent of their 613,000 emergency room visits.

Twenty-three of these children's hospitals were able to measure the impact of the title XIX cutbacks, and report that the effect of a 15-percent reduction in revenue from a 5-percent cap would amount to $23.7 million.

This is equivalent to the cost of 459,000 ambulatory care visits, a reduction equal to 11 percent of all such visits in all children's hospitals.

Mr. Chairman, a capping of medicaid funds will cause great difficulties for these hospitals in funding the essential health care needs of poor children.

If, in spite of this impact, there should be a cap, it is the recommendation of the association that an appropriate historical percentage of medicaid funding be earmarked for children.

We have spelled out the rationale for this in our statement.

Finally, the association states that the proposed reimbursement at the level of freestanding end stage renal disease programs does not reflect the special needs of children, and proposes a tax incentive to increase donations of kidneys for transplantation which can reduce program expenditures.

The association states that the proposed elimination of the ESRD networks will cause the special needs of children with ESRD to go without the planning, coordinating, and quality control benefits which the network can accomplish.

Mr. Chairman, we appreciate the opportunity to present our views on the administration's spending reduction proposals and their effect on the health care of children.

I would be pleased to answer questions.

Senator DURENBERGER. Thank you very much.

Dr. Cohen, would you address the figure 25 percent of the block grant reduction. You talked about the administrative savings that come from consolidating categoricals, is there 25 percent savings in maternal and child categorical grant programs, which are blocked?

Dr. COHEN. Well, first of all, as presented, as I understand the administration, we are opposed to the concept of block grants per se. We are in favor of consolidation of programs.

Senator DURENBERGER. Consolidate them into title V?

Dr. COHEN. Consolidate them into a title V structure, which can be more effectively administered and can bring together some of the divergent elements that currently exist which were testified to before.

I think we have a long way to go to make that program more effective. I think these special projects represent the very important investment in the long-range future and we're very upset and concerned to see the elimination of that in the role of training and the role of various successful university centers eliminated in that.

I view that 25-percent cut, however, in a broader context as a pediatrician who sees children three times a week, in addition to my other administrative responsibility, and that is as someone who is trying to help handicap children and see that these title V funds being cut back across the board are literally taking crutches and braces away from children who are now getting them through the State aid program, and whose evaluations are being paid for in the State aid programs that we are linked to.

So, I see that kind of reduction as having a very serious and dramatic impact, and, in fact, 65—we are only serving, according to current estimates, 65 percent of the handicapped children, which is my own personal involvement and interest around the country. Obviously, any 25-percent cut will decrease the amount of services and in the context of your earlier question, will, in fact, not permit the delivery of services to all those who require them.

Senator DURENBERGER. Thank you.

Ms. Klauck, a sort of a similar question of you, I guess.

I understand your testimony to be in opposition to the block grant, and also to oppose the blocking of maternal and child with, in effect, competing health care proposals; am I correct in that?

Ms. KLAUCK. That's correct, Mr. Chairman.

Senator DURENBERGER. OK.

Ms. KLAUCK. We really support the present structure and program and see that it has done very good things. We would like to see some changes in consolidation as the other two witnesses have testified to, but, basically, the present structure is very good.

Senator DURENBERGER. What about the position on blending title XIX and title V funding? Can you suggest an easy way to do that, or a logical way to do that?

Ms. KLAUCK. How I wish I could. The concept, I think, is one that's very valid and good because it would consolidate these various programs. As we have been discussing, so many of the programs are scattered throughout different titles and different ways of administration so there possibly is duplication or waste, and by organizing them into one system, I think we could do a better job, be more efficient and save some money and give the kind of care that mothers and children need, and cover all the various programs.

Senator DURENBERGER. OK. On the end stage renal disease program, I know you were sort of consolidating your testimony, but that is a big ticket item in this committee and one that is being targeted for very close examination, and I think you have suggested that altering reimbursement of facilities and repeal of the provisions regarding networks is not appropriate.

You mentioned something about tax incentives, and I don't know to whom or how those tax incentives would be directed. One of the suggestions that's been made is to encourage families with private insurance to begin to shoulder part of the cost burden for the care of children with end stage renal conditions.

Would you elaborate a little bit on just what your position is on changes in this program?

Ms. KLAUCK. Well, one of the problems with the program, as we understand it, is that it becomes very costly. The treatment procedure is a very costly one.

In the case of children, if they continue to be in the dialysis program, the average cost of the dialysis per year is $22,000 and it goes on through their entire life.

Over the number of years that a child is expected to live, that becomes a very costly project.

The best treatment for these children would be transplant. And one of the problems is the supply of kidneys. And if we could work out a program whereby there would be a greater supply, possibly an incentive program where people would receive a tax break if they did donate their kidneys, these children would have the opportunity to have a transplant.

It wouldn't apply only to children; it would apply also to adults and that means that their quality of life would be improved, as well as that extended cost of $22,000 a year for the dialysis procedure would be eliminated.

Senator DURENBERGER. Do you want to comment on that phase of it at all, Dr. Cohen?

Dr. COHEN. As, again, a pediatrician, I think the end stage—any kind of chronic disease is costly and very difficult to furnish in a competitive environment. I think that between handicapped children and end stage renal disease, we are talking about two of the most expensive items in long-range care for the children.

And I think what clearly has to be focused on, if I may presume, Mr. Chairman, is what we are investing in prevention and how we can use the maternal and child health program and title XIX as well to try to identify these handicapping conditions as early as possible. Develop our expertise and technology and try to prevent these long-term costs, and that is what I am concerned about in terms of those cuts which take out the funding for technology, for training, for attempts at developing new preventive techniques to prevent these long-term disabilities which are so difficult for children and their families as well.

Senator DURENBERGER. Thank you very much both of you for your testimony.

We appreciate it very much.

[The prepared statements of the preceding panel follow:]

STATEMENT OF HERBERT J. COHEN

SUMMARY OF RECOMMENDATIONS

I. *Retain Title V with specific improvements and consolidations:* The program was created to exert Federal leadership. The Title V program has had enormous impact in promoting the health of mothers and children, reducing mental retardation and other handicapping conditions, and rehabilitating crippled children. The Federal program represents a fraction of the expenditures at the State level but has led, not impeded, progress in the States.

II. *Reduce Spending—SHORT TERM:* (A) Reduce Administrative expense at the Federal and State levels by consolidating into an Administration for Maternal and Child Health the following programs:

Sudden Infant Death Syndrome (SIDS), Genetic Diseases, Hemophilia, and the non-financial portion of SSI Disabled Children's Programs.

(B) Reduce administrative expenses at the Federal and State levels by (1) use of a more formal process of developing planning priorities for expenditure of funds which would allow for more formal State MCH/CC participation in the setting of priorities, as well as comment by nationally recognized experts, and (2) expanded use of a peer review process for individual project award.

III. *Reduce Spending—Long Term:* Adequate health care of expectant mothers, newborn infants and high risk and disabled children reduces disabilities, and therefore public and private costs of treatment and welfare payments. Increased long

term savings in Federal programs for the disabled will obviously be reduced as the incidence and degree of disability is reduced. It is recommended that: (A) The MCH program be recognized as a preventative program and continued at its current level. (B) Congress direct that the preventative aspects of this title be strengthened and that State formula grant funds and Federal discretionary funds be targeted to a greater degree on primary and secondary prevention. It is also recommended that a greater portion of the funds be allocated to the development and implementation of cost effective methods.

IV. *Preserve Authority for Federal Leadership:* The current discretionary authorities under Title V (Mental Retardation projects, projects of national and regional significance for maternal and child health and crippled childrens services, training (including University Affiliated Facilities) and research) provide a fundamental tool for Federal leadership in bringing technically adequate health practices to underserved areas. The preservation of these authorities at the Federal level is essential to accomplishment of the basic purpose of Title V programs. Authorization should be made for discretionary projects in support of Federal leadership in approximate proportion of 20 to 22 percent of the total appropriations for Maternal and Child Health. Authorization at the current level of $46.8 Million for mental retardation projects and MCH and CC projects of national and regional significance, and $30 Million for research and training would satisfy this objective.

BACKGROUND: MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

An estimated 3 percent of the U.S. population suffers from mental retardation or other developmental disabilities. These conditions have a profound and often devastating effect on both the directly affected individuals and their families. The divorce rate is significantly higher for parents of children with developmental disabilities. There are over 200 known causes of mental retardation, but the known causes explain less than half the cases diagnosed. The cost to society of this disability is enormous. It has been estimated that the Federal government alone is spending 4.6 billion dollars on the treatment and care of individuals with mental retardation.

The impact of research on cases, prevention, treatment, and the dissemination of research findings to States has paid great dividends and offers great promise. It has been estimated that for each case of severe retardation among males that is averted, the undiscounted total gain to society is almost $900,000 (1970 dollars). The President's Panel on Mental Retardation in 1962 observed that "the Panel has been mindful of the significant advances in the attack on mental retardation which have taken place as a result of research findings. Such errors in inborn metabolism as phenylketonuria, maple syrup urine disease, and galactosemia have been intensively studied and through the results of these studies, it has been possible to prevent many causes of mental retardation." In recognition of the practical potential for prevention and its importance in human and economic terms, President Nixon established as a national goal reducing the incidence of mental retardation by one-half by the year 2000. This goal, felt then and now to be a practical one which can be achieved through research and the disseination of knowledge to states, will save society and Federal and State governments billions of dollars.

Adequate prenatal health care and health care of infants and young children is the single most important means of preventing and reducing mental retardation, and other disabilities.

Program concept

Title V of the Social Security Act was established to enable "each state to extend and improve (especially in rural areas and in areas suffering from severe economic distress). (1) services for reducing infant mortality and otherwise promoting the health of mothers and children; and (2) services for locating, and for medical, surgical, corrective, and other services and care for and facilities for diagnosis, hospitalization, and after care for, children who are crippled or who are suffering from conditions leading to crippling" (Sec. 501). The extension and improvement of state services (in contrast to funding services per se) is and has been the basic purpose of the Act. The accomplishment of this purpose has been well served by an unusually able Federal administration of the program, demonstrating the impact of true leadership at the Federal level, of a kind which could not be accomplished by states alone. The component parts of the Title V legislation, in general, have functioned together in an integrated fashion.

Program goals

An excellent perspective on the true Federal leadership nature of the Title V program is gained through study of the Federal MCH objectives for fiscal year 1981 to fiscal year 1983. Note that every single one of the goals articulated has the

following two characteristics (1) Prevention of crippling conditions (2) provision of leadership to states (not to just fund state services, but to systematically get states to strengthen services where they are weak in the preventative area.

Federal leadership in the prevention area is vital and so critically important because at the state level states recieve pressure to respond to demands for direct services with most of the state residents needing services being voters. With scarce resources, states are hardly able to deal with direct demand. To divert service dollars, where services are not being demanded and there is no immediately visable need to the laymen, or to provide services to children who cannot vote, or to provide services to prevent conditions from occurring at all calls for a national leadership. history shows that states with severe pressures of their own have been unable politically to make the choices necessary for preventative services so vitial to the national interest.

In addition, because of the rapid rate of research discoveries and breakthroughs over the last 2 decades, no state is in full possession of the technical know how to plan, train service personnel, and provide technical facilities necessary to complement fully effective preventative services. Federal leadership is vital to accomplish the technical transfer to the states.

MCH OBJECTIVES FISCAL YEAR 1981 THROUGH FISCAL YEAR 1983

Family planning

Increase the number of high-risk low-income women provided family planning services in Title V supported programs by 10 percent.

Assure that mechanisms are in place so that 90 ercent of patients 19 years and under who are receiving medical family planning services receive counseling prior to or at the time of receiving any family planning method.

Services for handicapped children

Assure that the SSI/Disabled Children's Program becomes fully operational in all 50 States and the District of Columbia and that at least 65 percent of the eligible children are under care.

Assure that the State Crippled Children's Program develops linkages for the provision of diagnostic and specialized services for handicapped children with at least 25 percent of the BCHS—supported primary health care programs located in the State.

Establish and implement interagency collaboration between MCH/CCS/SSI programs and:

(A) State Special Education Programs
(B) Title XIX
(C) Vocational Rehabilitation
(D) Other services, such as mental health, developmental disabilities, supplemental food programs, child development (Head Start).

Adolescent Health

Assure that participation of 60 percent of all pregnant adolescents 19 years of age and under in prenatal care during the first trimester of pregnancy in Title V and related programs such as special programs for adolescents.

Increase by 15 percent the number of adolescents, including handicapped adolescents, receiving comprehensive health services.

Prenatal care

Assure the participation of no less than 75 percent of all pregnant women 20 years of age and above in prenatal care during the first trimester of pregnancy in Title V programs.

Assure that at least 70 percent of women receiving prenatal care in Title V programs are screened for high-risk conditions by instituting a scoring system in Title V programs providing prenatal care.

Assure the participation of 60 percent of all pregnant adolescents 19 years of age and under in prenatal care during the first trimester of pregnancy in Title V and related programs such as special programs for adolescents.

Perinatal care

Decrease the neonatal mortality rate by 10 percent in all States having neonatal mortality rates above the national average (9.9 percent) in 1977. (22 States)

Achieve for every subgroup of the population as defined by socio-economic, ethnic and geographic characteristics a rate of low-birth weight that does not exceed 10 percent of all live births (1975-77 rate for whites is 6.1 percent, for blacks it is 12.9 percent).

Assure that mechanisms are in place to screen 90 percent of all newborn infants for metabolic disorders and that appropriate followup and management can be provided for infants with positive findings.

Child health care

Assure that the Title V State Plan(s) for MCH and CCS include documentation of the magnitude, nature and location of unmet need in the State's mother and child population, including handicapped children, and that areas of need (geographic and programmatic) are prioritized.

Assure that 90 percent of all medicaid eligible children served by the State MCH/CCS programs are under continuing care. (Continuing care is defined as the provision to a child of preventive, acute, episodic and health assessment services by or coordinated by a single primary care provider who maintains a consolidated medical record for that child. More detailed guidance on continuing care will be available from BCHS.)

Assure that at least one demonstration tracking and monitoring system is in at least one geographic area of the State to assure that all infants and children, particularly the newborn and those at high risk, are under supervision of a health care service provider and receive periodic followup.

Assure that 30 percent of all children 12 years of age and younger are fully immunized against preventable childhood diseases and establish systems in each community to assure that all newborns are immunized at the earliest appropriate time.

How Federal leadership is exercised to achieve goals

An example of how the various portions of Title V have worked together effectively to improve prevention in the states is phenylketonuria (PKU), a metabolic disorder which if present at birth will inevitably lead to mental retardation. If detected at birth, and properly treated, mental retardation can be completely prevented. Before current treatment methods for PKU were developed, MCH at the Federal level, using MCH projects of national significance funds (reserve B), organized a large nationwide multistate screening and testing study known as the PKU Collaborative Study. This study was of a scientific, geographical and financial scope such that no single state could ever have undertaken it. The project was quite successful and established PKU as an identifiable and treatable condition. However, the scientific methodology used in the study was too expensive for use in the individual states. To remedy this condition MCH then used the (Reserve B) mental retardation funds and funded Dr. Robert Gutherie to develop an economical mass screening tool. This also was a successful effort, resulting in the development of a single uniform screening test for use on babies at birth, a test which now costs 33 cents per baby. MCH then worked with the State MCH Directors and the University Affiliated Facilities (UAF's) under the state MCH formula grant program and the 511 training authority respectively to bring this technology to the states. This effort was successful; 48 states now have mandatory PKU screening for all newborn infants. At present the UAF's are working nationally to demonstrate within states proper and effective methods for treatment of PKU. The treatment is technically complex and the UAF's operating on a mulit-state regional basis are playing a vital role in demonstrating to states how such treatment can be effectively offered. The current MCH program provides for Federal leadership and a Federal/State partnership. Continued Federal leadership, in partnership with States is vital for the continuation of such programs.

Ongoing research offers great promise

Much is being done in the biomedical sciences. We are annually discovering new applications of fundamental techniques developed in this field 20 years ago, such as prenatal diagnosis through amniocentesis and karyotyping, with new capability of diagnosing a wide variety of potentially retarding disorders. Such advances must be followed up with appropriate treatment methods in order to forestall the consequent mental retardation. Research on characteristics of cell membrane functioning and malfunctioning promises to shed new light on a wide range of behavioral and structural developmental phenomena. Similarly, basic research on neuronal growth has reached a critical stage at which the promise of new understanding is great and the need for uninterrupted research is compelling. New research on brain enzymes, acting at the vital synaptic junction of neural cells, promises to provide extremely important keys to both the understanding of brain functions and the possibility of enhancing brain functions through biochemical intervention.

An example of research in the mental retardation research centers co-located with UAF's that has shown significant promise but is still going forward and will require continued investment to complete follows: Research on the structure of the

hypothalamus has revealed a group of cells that appear to act as "scavengers," protecting the brain from viral infections by attacking invaders such as viruses. As is true for other organs, there may be a critical period when these scavanger cells are not fully developed or functioning. Identification of this critical period, now under investigation, could help to prevent brain damage caused by a viral infection in the mother or infant, and thus prevent a major source of mental retardation.

The rapid pace of research discovery defines a vital MCH Title V leadership role, as the PKU example illustrates. Given continued Federal sponsorship of research and Federal leadership in making these findings available to the States, the goal of reducing the incidence of mental retardation by one half by the year 2000 can be achieved. There is no way the states alone can accomplish this goal.

The importance of training and UAF's

"Training" is funded under Section 511, but the word "training" is a misnomer. The authority is concerned with systematically making available to states the technical knowledge developed through research in practical ways which can be applied in the States. Among other projects, two national networks of University-based centers have been created under Title V: University Affiliated Facilities (UAF's) and Pediatric Pulmonary Centers. These centers serve mulit-state regions and have as a purpose bringing to the states technical knowledge needed but not otherwise available in the states. Table 1 presents an activity summary for the UAF's which tells only part of the story.

TABLE 1.—*UAF training program, fiscal 1979* [1]

Category of participant:	*Participants* [2]
Intensive/long-term university training	918
Formal university training	17,995
Short-term university training	61,090
Technical consultation: Service providers, parents, others	166,029

[1] UAF Direct Client Services fiscal year 1979: The 47 UAF's provided direct services to 68,200 individuals with disabilities in fiscal year 1979.

[2] Figures abstracted from "University Affiliated Facilities An Important Program for Developmental Disabilities". R. Lee Henney, Ph.D.; Institute for Comprehensive Planning; March 1981. All data in this report was drawn from the AAUAP Database.

The UAF's demonstrate a full range of services which incorporate all the latest research findings. (e.g. treatment of PKU). They thus serve as a resource for all states to visit, study, and learn the latest and most effective methods UAF's train at all levels professionals and practitioners in the latest methods. Two of the current state MCH program Directors received intensive long term training at UAF's. Thus, UAF's are directly contributing to the most effective possible technical leadership at the state level. UAF's also train faculty at Universities in their regions on what to teach professionals in training in relation to latest methods (e.g. the UAF at Johns Hopkins University trains all medical students in mental retardation with the goal of having general practitioners and pediatricians able to recognize at the earliest possible time mental retardation danger signs, so referral to experts can be made).

UAF's also carry a large client load and generally accept cases that no one else in the states has been effectively able to diagnose or treat (tertiary diagnosis and treatment). This service makes UAF's a national resources for treatment of complex and complicated cases (68,200 cases were seen by UAF's in fiscal year 1979) which would be lost if Sec 511 were not continued at its current level. Providing services to these individuals allows UAF's to learn about the problems in diagnosis and referral that agencies within the state are having and allows the UAF's to work with the state MCH programs to up-grade service within the state. Given the rapid rate of research findings in the field, this process is not one that is in any way critical of the states, but it is a natural, dynamic process in which the highly technical UAF's work with states to apply in a practical way new and more effective methods.

This process has allowed UAF's to support programs outside the Title V field. For example, UAF's have been analyzing referrals from public schools operating under Public Law 94-142 and have provided formal guidance to state and local education agencies on how to operate state education programs for the handicapped more effectively. UAF's are offering technical assistance to regional Headstart projects on how to serve handicapped children in Head Start programs. ICFMR inspector training programs have been designed and offered by UAF's. UAF's also offer training to state planners for Title XX services to the mentally retarded.

Cost effectiveness of UAF program

Mental Retardation costs the nation 12 Billion Dollars a year (Copeland, 1981) with $5 billion in Federal funds being used to serve this population. Statistics from

one UAF (UAF at Albert Einstein College of Medicine) illustrate the cost effective role of UAF's.

The Einstein UAF is a key tertiary care provider for over 5,000 severely handicapped children annually. Referred to this center are multiple handicapped individuals with the most difficult and complex problems.

In the past year, 20 cases of fetal alcoholism (a syndrome first identified at a UAF) were diagnosed in this clinic. In such cases, the children affected by maternal alcohol intake are usually moderately-to-severely mentally retarded. Through successful outreach and counseling efforts, we have succeeded in avoiding at least 10 subsequent pregnancies that would have resulted in affected offspring who would require special services costing at least $1.5 million over their lifetime. The total saving in these cases was $15 million. Early referral for genetic counselling of parents with Down's Syndrome have avoided the birth of at least two Down's Syndrome children in the past year—a total saving of $3 million.

Therefore, in but one UAF, outreach components of a $250,000 Maternal and Child Health grant, without exaggeration, resulted in an $18 million long term savings, over a 70 fold return on a one year investment. Added to this are substantial savings from other program components resulting from outreach, early identification and intervention activities for handicapped children. The gain from the programs results in substantial cost saving, estimated at around half a million dollars per child.

University Affiliated Facilities—A Capacity Building Program for the Developmentally Disabled

Introduction

Mental retardation and developmental disabilities have multiple causes, many of which take specialized knowledge, skills and resources to diagnose; if detected early many can be prevented or dramatically reduced in severity, with substantial savings to government expenditure.

The University Affiliated Facilities (UAF's) form a national network of 47 facilities in 35 States where children and adults, through high quality demonstration programs, are provided diagnostic and other services. UAF's are responsible for: serving individuals with complex disabilities for which services are not otherwise available; training professionals in their States and regions to promote proper diagnosis and treatment in statewide services; and, assisting state and local planning agencies to organize necessary services.

As a national network, UAF's work with National Institute for Child Health and Human Development (NICHD) supported Mental Retardation Research Centers to ensure that the latest possible knowledge is available throughout the service system. The national UAF network also works with hospitals, well-baby clinics, teenage pregnancy clinics and other programs to provide leadership to states and local communities in applying knowledge, tests, and services to prevent the occurrence of mental retardation and other developmental disabilities.

Legislative and Funding Background

Legislation signed into law in 1963 (Public Law 88-164) led to the development of the University Affiliated Facilities. The passage of Public Law 88-164 signaled a major breakthrough in bringing the resources of the Federal government to bear in the effort to more systematically address the manpower needs for care of this nation's mentally retarded citizens. For the first time, the Congress and the Executive branches recognized the need for Federal funds to assist in establishing a nationwide network of university affiliated interdisciplinary training programs centered on models of service. Implicit in this commitment was recognition of the need to give high priority to training professionals in the theory and practice of interdisciplinary programming for mentally retarded persons. With the passage of amendments to the Developmental Disabilities Act in 1972 and 1978, the mission of UAF's was expanded to include other developmental disabilities in addition to mental retardation.

UAF's are now funded as follows: 23 programs were granted construction funds under Public Law 88-164 during 1964 and 1968, when a 20-year joint commitment was made between the Federal government and participating Universities; approximately two-thirds of funds appropriated under Maternal and Child Health Research and Training provide program support to UAF's; UAF fund under the Developmental Disabilities Act provide administrative support to the constructed UAF's and fund UAF activities in states which did not receive construction funds. In addition,

UAF's are heavily supported by state and university funds, with approximately one half of UAF activities being funded by non-Federal dollars.

PROGRAM RATIONALE

Mental retardation and other developmental disabilities stem from many causes; although 3 percent of the population is affected, the causes are so varied that many are quite rare and therefore are harder to detect and identify. While most instances of mental retardation related disabilities are present at birth, only 1 percent of these cases are detected at postnatal medical examinations. Failures in detection are unfortunate; with proper treatment many potential instances can be prevented altogether, and other affected individuals treated so as to be indistinguishable from the "normal" population. In most cases, identification and treatment planning are highly technical and complex; failure to detect potential disabilities can be attributed to lack of adequate training on the part of professionals who do come in contact with newborn infants and pre- and school-age children. Dr. Hugo Moser, Director of the Universtiy Affiliated Facility at Johns Hopkins, has estimated that the incidence of mental retardation could practically and immediately be cut in half (without abortion) if proper training was given to appropriate professionals. In severe cases, as disabled children grow older, institutionalization or expensive community services are often required with an overall cost to society running as high as $1,000,000 per person. Denmark, in contrast, reports an incidence of mental retardation of 0.44 percent of live births.

Failing primary and secondary prevention, many studies show that, especially in the context of mainstreaming and deinstitutionalization, proper training of professionals in mental retardation and developmental disabilities (MR/DD) is vital if individuals with these handicaps are to be effectively served. For example, surveys show that the lack of adequate specialized training is the leading cause of problems in serving developmentally disabled children in Head Start school programs under Public Law 94-142 and in community living settings (citations on request).

UAF PROGRAM MISSION

The President's Panel on Mental Retardation in 1963 found that the entire field of mental retardation had a great deal of difficulty in attracting senior professionals. Professionals in general at that time (including medical students deciding on fields of specialty) tended to feel that: (a) specialization in mental retardation meant contact with undesirable institutional settings; (b) the mentally retarded were unrewarding to work with as clients; and (c) career prospects were unattractive.

A second finding of the President's panel was that the training given to the various professionals was too narrow too single-discipline oriented. Mental retardation and developmental disabilities affect the whole child (or adult) and the family in many ways, not just medical, for example.

To counter this, the UAF program was conceived, in part, to establish a highly rewarding and attractive place for top quality professionals to work, thereby serving to attract into the field of MR/DD the highest quality professionals. UAF's were also created to correct the Panel's second finding in a two fold way: (1) by developing and practicing interdisciplinary services, and (2) by helping to reform the training of every relevant professional so that all professions would see the necessity of an interdisciplinary approach in dealing with mental retardation and developmental disabilities.

The best diagnostic and treatment services for the developmentally disabled and mentally retarded are, at the same time, the best economic policy for the United States. When services are aimed at a rounded habilitation program with the goal of independent functioning, three results are achieved:

1. The mentally retarded individual leads a more fulfilled and dignified life.
2. Stresses on families of the mentally retarded are relieved.
3. Economic resources required for expensive institutionalization and maintenance (estimated to cost up to $1 million over the life of a mentally retarded individual) are saved for more beneficial treatment and government savings.

When screening and diagnostic services achieve prevention of mental retardation, savings are realized through the absence of costly programs resulting from faulty or late diagnosis.

UAF's serve the Nation, their regions, states, and localities through exemplary service, training working professionals and future leaders in the field, and through research and dissemination of the latest knowledge on effective and efficient methods of treatment.

Through their innovation and leadership, UAF's have built the capacity of local and state treatment systems and broken the barriers between states for effective

and cost efficient regional treatment programs. Through their activities in actual treatment and diagnosis, UAF's represent a bridge to bring about new program development among relevant agencies within a state. Furthermore UAF programs have been notable by accepting high standards as part of a national network and organization (AAUAP) dedicated to developing and implementing new methods and technologies. An outgrowth of the leadership role and demonstrated expertise, UAF's are now regarded as the key source of tertiary care for mental retardation and developmental disabilities in their communities, States, and regions.

On a national level, UAF's have the lead role in bringing new knowledge to the field. This role is facilitated through the co-location of ten UAF's and Mental Retardation Research Centers (MRRC). UAF's are able to stimulate MRRC research based on real need and are further able to implement the results of successful research and spread those results to affiliated local and state agencies. In addition, UAF's are able to serve a national role in evaluating other applied research and implementing techniques at their facilities and affiliated agencies.

The thorough and rapid translation of useful research to diagnostic and treatment settings has the direct result of improving the quality of care for individuals and the operating efficiency of UAF treatment programs and those of surrounding agencies. Through a leadership position in research and training, UAF's train individuals for positions of leadership in national, regional, and state Developmental Disabilities programs.

The second national function performed by UAF's is the development and implementation of state-of-the-art techniques and technologies that can be used by all service providers for the developmentally disabled. UAF's pioneered the use of telecommunications (audio conferencing, electronic mail, tele-lecturing) as a means of extending needed service and training programs to underserved populations. These efforts have placed UAF's in a leadership role for public and private sector organizations in taking advantage of new cost efficient communications systems. In addition, UAF's 7 years ago developed a comprehensive database system for documenting and analyzing training and service activities to monitor current programs and meet future needs (see I.C.P. Special Report for UAF database profiles). Other national state of the art programs include prevention technology (regional PKU screening programs), programs for the aging developmentally disabled, integration of the developmentally disabled into Head Start settings, manpower planning, coordination of services to the handicapped under Title XX, and new methods of promoting effective and efficient service delivery.

The combined national efforts of UAF's translate directly into benefits for regional, state and local agencies and services providers. The following two examples are indicative of the regional focus of UAF's: (A) In the area of diagnosis and treatment, UAF's play a key regional role. Many UAF's see clients from surrounding states and provide technical assistance to Agencies in surrounding states. (B) In the area of screening and diagnosis, UAF's provide genetic services accessed by surrounding states. The UAF's represent the only national network of genetic services specifically for the developmentally disabled.

UAF's extend their influence beyond their states of location through the active outreach to surrounding state agencies and programs for training and necessary support services. They offer the potential for rational, systematic resource use for complex issues and conditions. In addition to the national role as innovators and researchers, the regional role as providers of needed training and services, UAF's serve their particular states and local communities in a broad range of activities.

(A) UAF's are often the key tertiary care providers for their local communities and technical assistance resources for their states. A sample of twenty-one UAF's indicated that together they provided full spectrum care for over 23,000 developmentally disabled individuals. In addition, the 47 UAF's combined maintain coordination, technical assistance, and consultative relationships with over 1,200 local and state agencies. (B) In the area of training, UAF's provide a key resource for in-service and other special training for DD students, professionals, and paraprofessionals (nearly 100,000 trained fiscal year 1979); extensive training for students in DD related fields (over 14,000 trained fiscal year 1979); training for interdisciplinary activities as required under the DD Act and Public Law 94-142; and special training for State DD Councils. (C) Finally, UAF's provide valuable leadership in the coordination of state and local treatment programs by bridging the gap between state, local, and voluntary agencies and service providers.

To understand the true strength and need for UAF's, it is only necessary to think of the DD Community without UAF's. All treatment, training, and research activities indicated in the Institute for Conprehensive Planning Special Report to Congress would be subtracted from the effort to provide effective and efficient services to the developmentally disabled; and no national, regional, state/local resource

would be available to provide an effective model and guide for the billions of dollars spent each year by all government agencies on the developmentally disabled.

STATEMENT OF PATRICIA H. KLAUCK

My name is Patricia H. Klauck. I am Executive Director of Children's Health Center, Minneapolis, Minn., and Chairman of the Board of Trustees of the National Association of Children's Hospitals and Related Institutions, Inc. It is in this latter role that I speak to you today. Our Association is composed of 73 Children's Hospitals. These hospitals admit 90 percent of the patients cared for in Children's Hospitals, provide over 2.6 million days of inpatient care per year, and experience 4 million outpatient visits. Their annual expenditures on behalf of children approach $1.3 billion.

These hospitals are well represented by other organizations which can speak to their interest as hospitals. By their very existence they are advocates for children. We come to you today in that role.

We would speak to three proposals contained in the Program for Economic Recovery; those on the Title V Maternal and Child Health Program, the Title XIX Medicaid Program, and the End Stage Renal Disease Program. We have furnished a detailed written statement to the Committee and I would touch very briefly on its highlights.

First in regard to Title V. The Federal role of coordination, stimulation, standard development, and program assessment of the Title V program has been integral to its success. The Federal-State-local partnership which has resulted is its strength. Its incorporation into a block grant mechanism with unrelated programs will dilute its benefits to mothers and children and reduce its funding to a purchase-of-services mechanism. The proposed reduction in its funding, which in recent years has not met the effects of inflation, reflects an unacceptable priority for the needs of mothers and children.

Mr. Chairman, in 1935 at the time the Title V program was enacted, the infant mortality rate in this country exceeded 60 per 1,000 live births. In 1980, this figure had dropped to 12.8. It is the view of the Association gained from the long years of experience with the Title V program that this has not happened coincidental to the Title V program. Rather it is a direct result. We are concerned that the states, driven by fiscal and political pressures, will not sustain this momentum.

I would now speak to the Administration's proposal to limit Title XIX Medicaid funding to 105 percent of fiscal year 1981 expenditures, which in turn would be capped $100 million below projected fiscal year 1981 outlays is the States which have already been planning to limit Medicaid eligibility and scope of benefits. A recent survey of the American Hospital Association shows that 30 states are planning such cutbacks, The addition of the Administration's proposal will result in further cutbacks in these 30 states, and reductions in benefits in eligibility in all the other states as well.

We must face the fact that a cutback in Medicaid eligibility or a reduction in its benefits will not reduce children's need for health care services. To the extent possible all Children's Hospitals will attempt to continue to serve patients who are in need, irrespective of their ability to pay. Indeed, 30 hospitals to which I will refer provided $16.7 million in charity care last year. But the Children's Hospitals, typically under funded, do not have a large cushion which they can fall back on to meet the cost of services for which they are not reimbursed. Endowments of these 30 Children's Hospitals averaged only $2 million each. The hospitals, of course, have an obligation to all children, including those who have been covered by Medicaid. As a consequence, essential but non-emergent services to those who have no source for reimbursement may have to be curtailed.

To measure the effect of these cutbacks we looked at data obtained from 30 of the Children's Hospitals. 35 percent of over 1 million inpatient days of care were provided to Medicaid patients. 19 of these hospitals reported that 43 percent of their 727,000 outpatient visits were Medicaid patients and 41 percent of their 613,000 emergency room visits.

Twenty-three of these Children's Hospitals who were able to measure the impact of Title XIX cutbacks, report that the effect of a 15-percent reduction in revenue resulting from a 5-percent cap would amount to $23.7 million. This is equivalent to the cost of 459,302 ambulatory care visits, a reduction equal to 11 percent of all such visits in all Children's Hospitals.

SUMMARY OF THE STATEMENT OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC., BEFORE THE SENATE FINANCE COMMITTEE

The National Association of Children's Hospitals and Related Institutions, Inc. in the interest of children's health care, addresses three proposals of the Program for Economic Recovery.

TITLE V

It is the position of the Association that the federal role of coordination, stimulation, and standard development of the Title V program has been integral to its success. The federal-state-local partnership which has resulted is its strength. Its incorporation in a block grant mechanism with unrelated programs will dilute its benefits to mothers and children and reduce its funding to a purchase of services mechanism.

The proposed reduction in its funding, which in recent years has not matched the effects of inflation, reflects an unacceptable priority for the needs of mothers and children.

TITLE XIX

The proposed cap on Medicaid expenditures will result in a 15 percent reduction in funds for children's health care services, given inflation, state cut-backs, and the cap itself.

In 23 Children's Hospitals, this will result in an expenditure reduction equivalent to the cost of 459,302 children' ambulatory care visits—equal to 11 percent of all such visits to all Children's Hospitals.

In the event of a cap, the Association proposes separate line item funding for Medicaid for children, at the 20-percent level of Medicaid funding historically expended for children's health care, with a similar requirement of the states; with subsequent development of program characteristics reflective of children's health care needs.

ESRD

The Association states that the proposed reimbursement at the level of freestanding ESRD programs does not reflect the special needs of children; and proposes a tax incentive to increase donation of kidneys for transplantation which can reduce program expenditures.

The Association states that the proposed elimination of the ESRD networks will allow these special needs of children with ESRD to go without the planning, coordinating, and quality control benefits which the networks can accomplish.

STATEMENT OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC., BEFORE THE SENATE FINANCE COMMITTEE ON THE ADMINISTRATION'S SPENDING REDUCTION PROPOSALS

Mr. Chairman, I am Patricia H. Klauck. I am Executive Director of the Minneapolis Children's Health Center, Minneapolis, Minnesota, and Chairman of the Board of Trustees of the National Association of Children's Hospitals and Related Institutions, Inc. It is in this latter role that I appear before the Committee today.

The National Association of Children's Hospitals and Related Institutions, known by the acronym NACHRI is composed of 73 Children's Hospitals located throughout the country, including the vast majority of the major teaching Children's Hospitals. These hospitals admit 90 percent of the patients cared for in Children's Hospitals, providing over 2.6 million days of inpatient care per year. Additionally they experience 4 million outpatient visits a year, and conduct extensive education and research programs. Annual expenditures on behalf of their patients approach $1.3 billion.

The Association is organized in the recognition of the importance of child health care, providing a forum of hospitals which specialize in the care of children. Its main purpose is to promote the quality of child health care through the dissemination of information and the promotion of research and education programs related to that care.

It should be noted that all members of NACHRI are members of other associations of hospitals, to which they look for articulation of their specific interests as hospitals. Only when policies, regulations, or legislative proposals germane to pro-

viders of health care reflect a particular impact on the needs of children, does NACHRI speak to them, pointing out their effect on child health care.

Mr. Chairman, by their very existence, these Children's Hospitals manifest an advocacy for the child. Unless it were felt that the child is different in his metabolism, in his reaction to the disease process, in his social and emotional needs, in his place in the family structure and in the organization of resources required to maintain or restore his normal health status, the institution dedicated solely to the care of children might be difficult to justify. The child is different, and we assume willingly the role of his advocate. Since this Committee is the only Committee of the Senate whose jurisdiction includes a program concerned solely with the health of children, the Title V program, we recognize that you, too, are advocates for children, and are pleased to join with you in considering their needs.

A little over one year ago, NACHRI testified to the Select Panel for the Promotion of Child Health. It will be recalled that this Panel was chartered by the Congress to report to the Congress and to the Secretary of the Department of Health and Human Services the status of the health of America's children and to recommend actions which would safeguard and enhance that health. At that time, it was the Association's recommendation that the Select Panel call upon the Congress and the President to exercise their ultimate leadership, by articulating a National Policy on Child Health to which every segment of our society—commerce, labor, farm, and city—can commit. This National Policy will place prime responsibility for the health of the child in its most logical locus—the child's parents or guardians and to the extent of his capability, the child himself.

Society as a whole will be charged to recognize its overall responsibility for the health of all children, and should be challenged to be supportive of the efforts of parents and guardians. For those unwilling or unable to do so, society will respond with such resolve and resources as necessary to insure the health of their, and its children.

Our position in this matter has not changed. All around us, within our individual institutions and within our society at large, we see the effects of the lack of an articulated national resolve concerning the health of children. The infectious diseases of yesteryear which were so damaging to the children of this nation, polio, diphtheria, tuberculosis, have been replaced in great measure by pathology which is well within the means of our society to reduce and indeed eliminate. We speak of the scourge of teenage suicide, of pockets of regrettably high neonatal and infant mortality, of substance and alcohol abuse, of child abuse and neglect, of environmentally acquired disorders and diseases. A National Policy on Children's Health will encourage us to address these needs.

Although those of us who staff these institutions dedicated to the care of children have devoted our professional careers to that care, we do not, Mr. Chairman, live in a children's world. We are extremely cognizant of the economic difficulties that beset our nation, and we are pledged as individuals and in the conduct of our institutions' affairs to contribute to the correction of these problems. Nor will we pit ourselves against the needs of the elderly, nor of the poor for food and housing and income maintenance. We recognize full well the importance of our country being economically and militarily strong. We would suggest to the Committee, however, that this nation's ultimate defense is its children, not so much in their ability to bear arms, but in their ability to be productive, contributing, alert, responsive citizens. To do this, first they must be healthy.

We do not believe that the American people in their overwhelming demonstration last November for change in the economic direction of our country said, "We can no longer afford our children."

We would speak to three proposals contained in the Program for Economic Recovery. These are the three which relate to the Title V Maternal and Child Health Program, the Title XIX Medicaid Program, and the End Stage Renal Disease Program.

We will not burden the Committee with recitation of the endless statistics on children's health care needs, gleaned from the same volumes and reports which are available to the members of the Committee and their staffs. The institutions which are members of this Association interact daily with thousands of children and their families. They are staffed by dedicated, knowledgeable physicians and directed by competent trustees, volunteers who give unselfishly of their time in the interest of the children of their communities. When it comes to children's health care and their needs, we would state with quiet certainty, Mr. Chairman, that we know whereof we speak.

TITLE V MATERNAL AND CHILD HEALTH PROGRAM

It is proposed that the Title V programs for Maternal and Child Health and Crippled Children's Services be merged with 14 other categorical programs into a Health Service Block Grant Program for distribution to the states. It is our understanding that states would be authorized to transfer among program activities funds within the block grant.

Were Title V a process for allocating federal funds to the states for the sole purpose of the purchase of services provided mothers and children, a block grant approach might be justified. Because of the Committee's long time jurisdiction of Title V, its members know that it is not just a purchase of service mechanism, and realize that judgments made as a consequence of such a misconception can retard seriously the improvement of the health status of mothers and children.

Since its enactment in 1935, Title V's Maternal and Child Health, Crippled Children's Services, Research and Demonstration projects have made a major contribution to the well-being of this nation's mothers and children. In 1935, the infant mortality rate in the nation was in excess of 60 per 1000 live births. In 1980, this figure had dropped to 12.8.

In 1935, there occurred 50 maternal deaths per 10,000 live births among whites, and 120 per 10,000 live births among non-whites. By 1972, the rate had fallen to 1.82 per 10,000 live births. By 1980 this figure was so low as not to be reported in standard compilations of health statistics.

In 1935, America's social conscience was just beginning to stir concerning the plight of the crippled child. In half the states, no public funds at all were expended for the care of handicapped children. In 1981, the handicapped child has available to him a wide range of health, educational, and other services to help him achieve his full potential in the nation's social structure.

The Title V program alone has not achieved this great progress. A variety of forces, both public and private, tangible and philosophic, have led to these accomplishments.

Nor has the provision of direct service to patients provided by Title V funds been the major cause of this improvement; for its funding levels have not and could not approach the need.

The Title V program has been a major focal point around which those dedicated to the improved status of mothers and children could coalesce. Through the creation of a unique federal-state-local network aimed at not just provision but at the improvement of care, it has in the 45 years of its existence resulted in benefits far beyond the purchasing power of its funding. It has provided an infrastructure for the identification, assessment, and addressing of needs of mothers and children. Its research has not been in the laboratory, it has been in the field, encouraging innovation in the delivery of services.

For this reason, the proposal to rescind $6 million in fiscal year 1981 Research and Training funds and eliminate such funds in fiscal year 1982 with explanation that such activities are funded in NIH does not seem appropriate. NIH Research of course, is scientific and clinical in nature, and does not address the organization and delivery of health care services. NIH training grants support the training of scientists, not practitioners or deliverers of care. In short, it is not duplicative.

Had Title V funds been directed just at the "laying-on-of-hands" for high risk new born babies, those funds would have been consumed with little appreciable effect. Rather this funding has been used in a variety of interrelated and successful steps: effective prenatal care to minimize and identify high risk pregnancies; education and counseling of mothers so identified; designation and stimulation of institutions to meet the critical needs of these patients in the birthing process; encouragement of development of high risk nursery services, including training of the variety of specialized personnel needed to staff them; effective family planning counseling services to help such mothers, and others, to plan for subsequent pregnancies.

In short, through the stimulus of the Title V program, a process has been developed which has the capacity to serve thousands and thousands of others, who may never have heard of Title V, nor been a direct recipient of its services.

Similarly, the handicapped child has benefited from a program approach to his needs. A comprehensiveness of care has evolved in response to the chronic nature of his handicap, involving the variety of professional disciplines needed to guide the child to his full potential. A case management conference for the child afflicted with cleft palate, for example, brings together the talents of pediatrician, plastic surgeon, oral surgeon, speech pathologist, otolaryngologist, social worker, and others concerned with various aspects of the child's condition.

Were Title V merely a mechanism for payment of services, the child's treatment could well be an uncoordinated, unrelated series of services with less than optimal outcome.

Nor should one suppose that the states, in administering this portion of any block grant would give increased consideration to needs of mothers and children. In its 1977 report on the Maternal and Child Health Program (Title V), the American Academy of Pediatrics has stated: "Generally speaking, the maternal and child health programs of many of states do not reach high on the list of states' priorities." The temptation to shift funds away from maternal and child health to other health programs included under the block grant umbrella may well be fiscally and politically difficult to resist.

It is the position of the Association that the federal role of coordination, stimulation, and standard development of the Title V program has been integral to its success. The federal-state-local partnership which has resulted is its strength. Its incorporation in a block grant mechanism with unrelated programs will dilute its benefits to mothers and children and reduce its funding to a purchase of services mechanism.

The proposed reduction in its funding, which in recent years has not matched the effects of inflation, reflects an unacceptable priority for the needs of mothers and children.

TITLE XIX MEDICAID PROGRAM

The administration has proposed that funding for the title XIX Medicaid Program for fiscal year 1982 be limited to 105 percent of fiscal year 1981, which in turn would be capped $100 million below projected outlays. The resultant fiscal year 1982 outlays will be $1 billion below those projected by the previous administration.

Twenty percent of Medicaid expenditures are for the health care of children. Since its inception in 1965, the Medicaid Program has had a major impact on the health care needs of poor children by providing payment for services rendered by health care providers. In so doing, the program has given them access to necessary health services which the poor previously were either unable to obtain or unwilling to seek out for their children. Prior to Medicaid, these children for the most part were dependent on the charity of public and private health providers for needed health and medical care. These private providers in large measure depended on philanthropy and the willingness of their staffs to accept less than equitable salaries to finance unreimbursed care. In spite of these contributions, funding generated was not adequate to need; many children went without care.

Many children of the poor continue to go without care, dependent as they are on the policies of the state in which they live as to whether they qualify for Medicaid. Nationally, only 40 percent of families below the Community Services Administration poverty level income figure receive Medicaid benefits. The child in Missouri whose family income is but $4,400 per year is not eligible; were he to live in Minnesota, he would be afforded access to necessary health care services by that state's Medicaid program.

Independent of the administration's proposed caps, states already have been planning to limit Medicaid eligibility and scope of benefits. Massachusetts plans a 20 percent cut-back in program. Kentucky and West Virginia may reduce eligibility; Illinois and Michigan may eliminate those who are "medically needy", up to now adjudged unable to afford the cost of health care. All told 30 states are reported in an American Hospital Association survey to have been planning Medicaid cut-backs.

Addition of the administration proposal will exacerbate these States' difficulties, reducing Federal participation in funding below anticipated levels. Further cut-backs will result in the thirty states reported, and in all other states as well.

The impact on children served by Children's Hospitals will be heavy. A survey of 30 Children's Hospitals throughout the country reveals that in the past year 34.74 percent of 1.072 million inpatient days of care were provided to Medicaid patients. Nineteen of the hospitals report that of 727 thousand outpatient visits 42.8 percent were by Medicaid patients; as were 41 percent of 613 thousand emergency room visits. Reporting on utilization of the very high cost neonatal intensive care units, 14 of these hospitals show that 21 percent of patient days of such care is for Medicaid patients.

The typical urban-core location of the Children's Hospital contributes to this heavy Medicaid utilization. In addition to drawing patients with complex diagnoses from a large referring region, these hospitals provide comprehensive primary care to increasingly large numbers of inner-city children for whom other sources of such care are not available. Total ambulatory care visits for all Children's Hospitals in 1979 was 4.2 million.

Unfortunately, cut-backs in Medicaid eligibility or reduction in benefits will not result in an equal reduction in children's need for health care. It may cause parents to postpone needed services, with the result that episodes of illness, made avoidable

or easily treated by a routine outpatient visit, will be seen only when their acuteness prompts emergency room services or inpatient hospitalization.

To the extent that Children's Hospitals are able to do so, their dedication to the well being of children will dictate that these children be provided care without regard to their ability to pay. However, a 1978 national study by the association showed that Children's Hospitals receive in payment but 93 percent of the cost of provision of care; and that among third party payers, Medicaid payments were the least adequate at 89 percent of cost. If anything, with the deteriorated economy, higher unemployment, and previous cut-backs in Medicaid programs, this situation has worsened.

Of the thirty Children's Hospitals referenced above, 16 report operating expenses in excess of operating revenues for the past year, totaling $18 million on revenues of $238 million. The 14 reporting excess of operating revenue over operating expense demonstrate on average a narrow margin of 3 percent. Any reduction in payment for services rendered poor children in these hospitals, unless accompanied by a similar reduction in the numbers of such children treated, clearly not in their interest, will erode this narrow margin. These 30 hospitals provided services in the amount of $16.7 million for which payment was neither expected nor received—the traditional charity care.

Hospitals typically compensate for under-reimbursement or lack of reimbursement by several devices; transfer of costs to other payers; seeking philanthropy; application of endowment income or other non-operating income. In the extreme, in a self-destruct action, endowment principal may be applied. In the thirty hospitals studied, endowment averages $2 million per hospital. The sole remaining alternative is to turn away patients in need of care.

In the instance of Children's Hospitals, their high level of Medicaid utilization indicates a smaller base of other payers to whom costs might be transferred; and there exists a growing reluctance by other payers to fund these costs. As generous as the public is in its charitable support of children's health services, in recent years philanthropy has been on a downward trend in real dollar terms. There appears to be a growing public resistance to subsidizing the cost of patients for whom government has assumed financial responsibility, and generated tax revenue.

The total available assets other than physical plant, including receivables of Children's Hospitals, if devoted to operating costs would sustain these hospitals for only 237 days. If applied totally to the under-reimbursement reported in 1978, by 1987 Children's Hospitals would be exhausted, empty buildings. Applied to income production and presuming a 10-percent investment return, these assets would generate income of $76 million, an amount not even adequate to meet the operating shortfall for all Children's Hospitals of $78 million computed conservatively on the 1978 reimbursement experiences, and with no capacity to allow for renewal and updating of capital plant and equipment and to undertake new services for children.

The sample of 30 hospitals reported above typify other Children's Hospitals in their concern for all children, for those 34 percent who are Medicaid eligible as well as those 66 percent who are not.

Under any cut-back in Medicaid funding, in order to meet the acute immediate needs of all children, Medicaid and non-Medicaid alike, essential but non-emergent services to those for whom reimbursement is not available may have to be curtailed. Twenty-three of these hospitals able to measure the impact of title XIX cut-backs report the effect of a 10-percent reduction will be a revenue reduction of $16.1 million in the coming year. A 15-percent reduction—not an untoward projection, given the combination of continuingly rising costs which hospitals must pay for goods and services, the proposed cap, and State inititatives—will increase this to $23.7 million. At this level, translated to the terms of essential children's health services, inability to fund from other sources will force a service and expenditure reduction equivalent to the cost of 459,302 ambulatory care visits to children—a reduction equal to 11 percent of all such visits to all Children's Hospitals. This in but 23 of the approximately 100 Children's Hospitals participating in the Medicaid program.

Among reductions in services contemplated by these hospitals, the following are reported:

> "Restrictions on the number of non-paying patients"; . . . "In each outpatient clinic service will be limited to specific volume"; . . . "We will have no choice but to restructure our outpatient services drastically"; . . . "Reduction in neonatal intensive care beds and cancellation of neonatal helicopter and ground transport services"; . . . "Out-reach and education programs will be substantially curtailed"; . . . "The number of beds for active pediatric rehabilitation will have to be reduced."

There are those who would suggest that hospitals can and should reduce costs by eliminating unnecessary expenditures. We would suggest, in return, that Children's Hospitals are engaged in a continuing effort to do just that; and that reimbursement at 93 percent of the cost of provision of services is a compelling reason to do so.

The association has attempted to assess objectively the consequences to children of capping Medicaid expenditures. Yet, as previously stated, the association and its member hospitals recognize the importance to the Nation's children and the hospitals which serve them, of a vital and stable economy.

If after assessment of these consequences, it is determined that children's health needs have no precedence over other needs and must share equally in the reduction in Federal expenditures, these institutions will work to see that the last to experience the resulting deprivation are the children themselves. Indeed, all concerned with the Medicaid program will be obliged to reascertain that the funds available for children's health needs are used most effectively.

We would suggest that the Committee's long involvement with the title V program brings to it a special knowledge and a special obligation, in the interest of children. Members of the Committee from both sides of the aisle, in speaking to the CHAP proposal in the last session of Congress, demonstrated an awareness of these needs. None is recorded as having spoken in denial of them, although the effectiveness and the cost of the legislative proposal then at hand was questioned.

It would appear that the imposition of any capping of Medicaid expenditures will turn its funding from an entitlement process to an authorization-appropriation process with finite dollar limits. In the event of the imposition of a cap, we would urge the Committee's consideration of separate line item funding for Medicaid for children, at the 20-percent level of Medicaid funding historically expended for children's health care service, with a similar maintenance of effort requirement by the states.

Good reasons argue for this. First is the Committee's interest in and knowledge of children's needs, gained from its jurisdiction of the Title V program.

Second, it would insure that children, voiceless in the political process, retain an appropriate share of the total funding in a future projected to experience increasing needs among other segments of the population.

Third, it will permit the Committee to address a basic flaw in Medicaid for children. Under existing law, regulation, and reimbursement practices formulated for the episodic inpatient-oriented care of the elderly under Medicare, the comprehensive, preventive, ambulatory emphasis of appropriate child health care is compromised needlessly. It is the view of the Association that the uncoupling of children's Medicaid from Medicare, with the development of program principles which foster effective child health care, can begin to accomplish what all found desirable in the CHAP proposal, while keeping costs within manageable levels.

Fourth, a central focus for child health care, to coordinate and insure the cost effectiveness of child health programs could be created within the Department of Health and Human Services. Good management technique alone argues for the development of an entity similar to the Maternal and Child Health Administration proposed in the report of the Select Panel for the Promotion of Child Health. As dollars grow more scarce, their management must become increasingly effective, if children are not to suffer needlessly from misapplication of resources.

Finally, a more appropriate blending of the funding mechanism of Medicaid and the programmatic orientation of Title V can accomplish in far greater measure the result cited for Title V's involvement in neonatal intensive care; widespread stimulation of the voluntary provider and the private third party sector toward appropriate patterns for child health care, without a concurrent requirement for federal funding.

END STAGE RENAL DISEASE PROGRAM

The Administration proposes that reimbursement for hospital based chronic renal dialysis treatment be the same as for freestanding ESRD providers, and that the ESRD Network coordinating Councils be eliminated.

Freestanding ESRD programs do not offer the same range of services, nor treat patients of equal complexity as do hospital based programs. Nor should they attempt to. Hospital based programs are the appropriate locus for such activities. Freestanding facilities' operating costs are, and should be lower. To establish a reimbursement rate lower than the expected legitimate costs of programs of necessarily greater complexity simply does not stand the tests of reason, if the quality of care provided beneficiaries is a consideration.

To understand the impact of children of each of these proposals, one needs an understanding of renal disease in children and their impact on the ESRD program.

In 1978, 4.2 percent of patients receiving outpatient dialysis in the Medicare program were under the age of 20. The relative impact of their care, in terms of total program costs, was not great, particularly if that treatment allowed these young people the opportunity to lead productive lives as contributors to the nation's social structure. That this goal was accomplished is demonstrated by statistics published by the Health Care Financing Administration for the fiscal year 1978 demonstrating survival rates for the end stage renal disease program participants. Survival rates for patients 5 to 14 years of age were 97.9 percent and for those 15 to 24 years of age were 92 percent, as opposed to the 70.4 percent survival rate for patients aged 65 to 74.

Treatment of children with end stage renal disease differs significantly from treatment of adults in several ways.

1. Goals, program philosophy and modality of treatment for children differ from those for adults.
2. Children have special needs related to physical, social, and emotional growth and development.
3. Special technical considerations are involved in dialysis of children.
4. Low incidence of end stage renal disease in children results in trade-offs between case load and catchment area size.

These differences result in higher costs for provision of dialysis services to children.

It must be recognized that end stage renal disease, untreated, is a fatal disease. Dialysis, if successful, ameliorates it to a chronic, life threatening disease. Only kidney transplantation, to date, affords hope for "cure".

The goal of ESRD treatment for children is restoration of normal function through transplant, as quickly as possible, so that the child may develop into a healthy, productive adult. The Section on Nephrology of the American Academy of Pediatrics has stated that virtually all children entering an ESRD program will be candidates for transplant, and will receive a transplant within one year of entry into the ESRD program. Dialysis then, is a temporary mode of treatment for children. Conversely, the goal for many adults, particularly those in the 65–85 year age range who constituted 21.7 percent of the 1978 recipients of Medicare outpatient dialysis, is maintenance of function with dialysis.

This emphasis on transplant for children should be of special interest to the members of the Finance Committee who have considerable and legitimate concerns about the cost of the end stage renal disease program. Through transplant, the ongoing cost of maintenance of the patient by renal dialysis can be eliminated. Absent a transplant, the cost of sustaining the patient on renal dialysis continues until the patient's death. There is no other known cure for the patient afflicted with end stage renal disease.

Yet the low incidence of the disease among children, and this very emphasis on early transplantation, so much in their interest and in the interest of the cost of the end stage renal disease program, results in lower utilization in children's dialysis programs and in significant fluctuations in utilization rates. This in turn results in higher costs of dialysis for children. The proposal for a lower reimbursement rate will have the effect of penalizing children's ESRD programs for their emphasis on transplantation. Children's programs' cost will be compared to costs of maintenance-oriented adult programs for purposes of determining the Medicare reimbursement limit. It could result in encouraging this maintenance-oriented treatment philosophy which can be accomplished at a lower cost, rather than the current cure-oriented philosophy extant in children's programs. The child who is a victim of such a change in philosophy will continue to generate program costs for years to come.

The hosptial providers of these special children's end stage renal disease services, unless they are able to generate subsidy of the end stage renal program from other funding sources, may be forced to severely limit or even discontinue the services now being offered because of the resultant inadequate reimbursement. Should such be the case, these children would be much the worse for it.

Unless the proposed reimbursement system contains within it a prospective exception request mechanism, hospitals will be expected to incur the cost of quality treatment with interim reimbursement at a rate much lower than costs, and then seek additional reimbursement based on these program costs only after the completion of a fiscal year. The exception process has proved to be slow and cumbersome. In the interim the provider of the service may experience a serious deterioration of cash flow, to the point that the effort can no longer be sustained.

The Association would suggest for the Committee's consideration a proposal based on the Finance Committee's jurisdiction of taxation. It speaks to the severe and chronic shortage of kidneys for use in transplantation and the federal government's ability to deal with this shortage through the tax process. In our view it would

create an incentive for donation of kidneys which in turn could work to reduce the numbers of persons dependent on dialysis for preservation of their lives.

We would suggest that the Internal Revenue Code be amended, to provide that a refundable tax credit of $5,000 be granted on the final tax return of an individual who has previously agreed to donate a kidney for transplantation upon his death, if indeed such kidney is suitable and is made available for transplant. It would appear that this would cause a reduction in tax revenues. In fact, if through the provision of a kidney and an individual is successfully transplanted and removed from the ESRD rolls, the $22,000 annual cost to the government of maintenance dialysis for the individual will be eliminated. In the interest of equity, our proposal similarly would include a refundable income tax credit to a family member who donates a transplantable kidney to an ESRD program beneficiary.

A second administration proposal calls for the elimination of the End State Renal Disease Networks, justified by the proposed phase out of the PSRO program and health planning. Resultant savings are projected at $6 million.

Were the Association's purpose to speak to the interest of hospitals, it would seem strangely out the vogue to speak in favor of retention of a regulatory process.

We speak, however, to the needs of children, and in that context, to the important role the networks can and should play to the benefit of children.

Only 4 percent of program beneficiaries are children. Their particular needs can, and have been overlooked. Without the coordinating role played by the networks, these very essential requirements of the child-patient could well go untended. For example, ESRD Network 10 for Texas and Arkansas has adopted quidelines calling for the child to be seen in consultation at a pediatric center within one month of beginning dialysis; consideration of early transplantation; special technical considerations in the dialysis of children; special dietary management; access to child psychiatry and social work services; and maintenance of the child's school program. Without the coordinating role provided by the network, it is questionable that ESRD programs providing care mainly to adults would be sensitive to or effective in meeting these special needs of children. It is doubtful that program directives from the federal level will accomplish this. At the regional level, the needs of the area can be identified and addressed.

In our view, in the interest of children, the elimination of PSRO's and health planning argues for the strenthening of network coordinating councils, not their elimination. If some of the networks have not performed at expected level, perhaps it is their direction from the federal level which needs to be addressed.

Their $6 million cost, quite modest for the important role these Councils can play, might be viewed in the perspective of the Health Care Financing Administration's estimate of fiscal year '82 ESRD program costs of $2.065 billion.

The Association appreciates the opportunity to present its views on the Administration's Spending Reduction Proposals and their effect on the health care of children.

Senator DURENBERGER. Our next panel of witnesses will consist of Dr. Mitzi Duxbury, dean of graduate programs, School of Nursing, University of Minnesota, Minneapolis, Minn., on behalf of the American Nurses Association and Ms. Sally Tom, Government liaison, the American Association of Nurse Midwives, Washington, D.C.

Welcome to both of you.

Do you want to go in the order I introduced you?

Go right ahead, Mitzi.

Thank you very much for being here.

STATEMENTS OF DR. MITZI DUXBURY, DEAN OF GRADUATE PROGRAMS, SCHOOL OF NURSING, UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MINN., ON BEHALF OF THE AMERICAN NURSES ASSOCIATION; MS. SALLY TOM, C.N.M., GOVERNMENT LIAISON, THE AMERICAN ASSOCIATION OF NURSE MIDWIVES, WASHINGTON, D.C.

Dr. DUXBURY. Mr. Chairman, I am Mitzi Duxbury, I am a professor and assistant dean for graduate studies in the School of Nurs-

ing at the University of Minnesota and I am testifying on behalf of the American Nurses Association.

I appreciate the opportunity to appear before the committee and I will present a summary of my remarks.

I ask permission for the full statement to be included in the record.

Senator DURENBERGER. It will be.

Dr. DUXBURY. Thank you.

The ANA is deeply concerned with certain aspects of the administration's current budget proposals. We recognize the need to reduce the Federal budget and provide for controls on spending. However, the health of the Nation is often reflected in its infant mortality rate.

The United States ranks 15th in the world. The health of our children and their families is the key to the health of a Nation. They are our most important natural resource. Without healthy children and families we, as a country, have nothing.

Most high-risk children come from high-risk families, the poor and the very young. Programs funded by title V have played a key role in reducing maternal and infant mortality and morbidity in establishing improved methods for the delivery of health care to low-income mothers and their children.

We have serious concerns about the consolidation of vital health service programs under block grants and the repeal of existing authorizing legislation, including title V, Maternal and Child Health.

Block grants for certain State-provided services may be appropriate if there is assurance that the moneys will be utilized as intended and clearly earmarked for comprehensive maternal and child health services.

Block grants to States are not appropriate for regionalized services, demonstration projects, nor research and training.

Research and training have national impact and are primarily our national responsibility. The administration has proposed a recision of $6 million from fiscal year 1981 training and research programs and recommends the elimination of funding for these programs in fiscal year 1982.

Funding for research under title V currently supports 46 projects, and only those projects that demonstrate the practical application of research findings are funded.

My own research, funded through title V, examines causal factors of nurse turnover in neonatal intensive care units.

Well-prepared nurses are essential for the optimal outcome of the high-risk mothers and babies. Preliminary analysis of the data suggests a high and signficant correlation between nurse turnover and neonatal mortality. Further studies are necessary to confirm or refute these data. High nurse turnover can be prevented.

The NIH does not fund applied research and maternal-child health.

In summary, I believe that research, training, regionalized programs and demonstration projects are a federal responsibility. Funding for these programs, although relatively small, have already made a significant impact on the improvement of maternal child health.

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Thank you.

Senator DURENBERG. Thank you very much.

Ms. TOM. Good morning. My name is Sally Tom, and I am a practicing certified nurse-midwife. I am representing the American College of Nurse Midwives and I am also speaking today from my experience as a nurse-midwife educator, and as a nurse and nurse-midwife in title V programs.

The question of safety and of quality of care is often brought up when the idea of nurse-midwifery is introduced. A considerable body of research documents the safety of nurse-midwifery care. All studies have shown that the risk to women attend by nurse-midwives is equal to, or lower than the risk to comparable groups of women attended by physicians. In fact, the literature reports striking reductions of infant mortality rates after the introduction of nurse-midwifery care.

Available data and the characteristics of nurse-midwifery care suggest that nurse-midwives are cost-effective. The characteristics include the use of nonhospital facilities, shortened hospital stays, nurse-midwives low salary relative to physicians', limited use of expensive technology, low Cesarean birth rates, and reductions in infant morbidity and mortality.

I would like to draw your attention to the cost analysis done by the University of Mississippi on page 8 in my full testimony.

When Federal funds are removed and not replaced by the States, nurse-midwifery schools will have to sharply cut the number of students accepted each year, some will close, care to indigent populations will be reduced and health care cost will rise.

All of us in nurse-midwifery education are aware of the need for dependable, renewable, financial resources.

Education program faculties are devising plans to shift their funding bases from soft to hard money primarily through establishing faculty practices as a source of faculty salaries and clinical sites for students. There is a tension, however, between the need to shift the funding base and the political reality of opposition to nurse-midwifery practice.

The opposition is widespread, comes in many forms, and appears to be motivated by a fear of the economic competition which nurse-midwives bring to the obstetrical market.

This opposition was the subject of a December 1980 hearing by the Subcommittee on Oversight and Investigation of the House Energy and Commerce Committee.

Until nurse-midwives are able to establish self-supporting faculty practices, nurse-midwifery education programs will need Federal or State aid. Until this country no longer has citizens who lack access to maternal and child health care and to safe options in maternity care, the Federal Government will need nurse-midwives.

As is shown by the data presented today, funds invested in nurse-midwifery education are moneys prudently invested and many times returned.

There is a group of recommendations on the last page of the full text of my testimony, which I would be happy to discuss with the committee. The American College of Nurse Midwives wishes to thank the Committee on Finance for inviting the college to testify

today. The members look forward to working with you in your efforts to safeguard the health of mothers and babies.

Thank you.

Senator DURENBERGER. Thank you very much for your testimony.

I think it was the day after the President's televised budget message that a group of people were sitting in my office reacting to—I think it was the Today Show or one of those morning shows—in which five victims of the President had been selected to talk about the problems and I didn't see the show, but apparently one of the victims was a nurse. One of the people in the office said, "I'll bet she had 25 telephone calls offering her a job right after that television program."

I wonder, Dr. Duxbury, if you could tell us if there is a nursing shortage in this country, and, if so, how we should deal with it?

Dr. DUXBURY. The American Hospital Association tells us that there are over 100,000 budgeted unfilled positions in hospital care today. We found a range in our own study as it relates to the delivery of maternal infant care of crude turnover ranging between 5 percent per year, which is very low, to 88 percent crude turnover a year, and hospitals we didn't pick up in our sample reported 130 and 180 percent crude turnover a year. This has a grievous impact on the kinds of care that is delivered to the mothers and babies.

There is also a qualitative issue. We haven't kept up with the appropriate levels of preparation to provide the knowledge and skill needed in high technology hospital care. That is, there are not enough baccalaureate prepared nurses in an appropriate ratio to associate degree and licensed practical nurses which we seem to overproduce.

The shortage is not a myth and it is partly a function of the service sector and partly a function of the educational sector.

Senator DURENBERGER. In other words, the educational sector hasn't quite kept up with the changes in the service sector; is that right? Is that one way to put it?

Dr. DUXBURY. Yes. We haven't prepared enough people at the appropriate levels to meet the service needs.

Senator DURENBERGER. Sally, do you have a reaction to that?

Ms. TOM. Well, there are approximately 2,200 nurse-midwives in the country; and we feel that 80 percent at a minimum, some people would say more, mothers have healthy pregnancies and since many of them would want nurse-midwives, we have a severe shortage of nurse-midwives.

Nurse-midwives in 1976-77, did an estimated 1 percent of all the births—normal births in this country.

The GMENAC report would like to see us doing approximately 5 percent by 1990. At our current educational output, we could not produce enough nurse-midwives to do that.

Senator DURENBERGER. I think your statement was that there were six schools of midwifery receiving title V funds?

Ms. TOM. Yes, that's correct.

Senator DURENBERGER. What percentage is that of the total program?

Ms. TOM. We have 25 schools, and of our 25 schools 3 are completely economically self-sufficient. The other schools which do not receive title V funds receive division of nursing funds.

Senator DURENBERGER. How many of those schools received State funds?

Ms. TOM. About half of these programs are in private universities. The rest of our programs are housed in State universities. However, in some of those State schools they are still largely dependent on Federal funding. I will be glad to find additional information about State support for the committee.

[The information was subsequently furnished to the committee:]

AMERICAN COLLEGE OF NURSE-MIDWIVES,
Washington, D.C., April 15, 1981.

HON. ROBERT DOLE,
Senate Finance Committee,
Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR DOLE: At the recent hearing on the Maternal and Child Health, Title V, programs Senator Durenberger asked for information about the involvement of States in funding of nurse-midwifery education. I have now completed a telephone poll of the nurse-midwifery education programs which are housed in State universities and which receive Federal monies. Two programs, at the University of Kentucky and the University of Illinois, receive no Federal funds.

Four programs, with a total yearly output of 56 students, receive no State funds directly; one of these States waives the tuition for the nurse-midwifery students (who sign one year commitments to work in that State after graduation if jobs are available) and thus contributes student support indirectly. These 56 students represent roughly one-eighth of the total yearly output of nurse-midwives which is between 200 and 250 annually.

Six programs, with a yearly output of approximately 75 students, receive both Federal and State funds. In two of the six programs, the Federal money supports half of the number of faculty supported by the State, in one the State and Federal monies support equal numbers of faculty and in another the Federal money supports double the number of faculty supported by the State. It appears from the data that in a fifth program the Federal money supports twice the faculty supported by the State. In the case of the sixth program, the data suggest that the State supports more faculty than does the Federal money.

The primary private contributor to nurse-midwifery education in State universities is the National Foundation/March of Dimes. Three of the programs housed in State schools receive March of Dimes funding. In one the money supports one administrative assistant position, in another it helps support a nurse-midwifery service and in the third in provides aid to students. The March of Dimes does not any faculty positions in nurse-midwifery education programs housed in State universities.

The faculty members, in most cases the program directors, with whom I spoke expressed grave concerns about the potential decrease in Federal funds. Some find it feasible to draw up plans to begin faculty practices, many are planning to reduce the number of students enrolled in next year's class and several have applied to State authorities for continued and increased financial support. Three programs have indicated that they would be forced to close without further Federal support. Two of these three programs threatened with closing already do receive some State funds.

Twelve nurse-midwifery education programs are housed in private universities and all but one of those rely heavily on money received from the Title V, Maternal and Child Health Training funds or from the Division of Nursing, DHHS. Three of those rely on Maternal and Child Health Training funds and the rest receive Nurse Training Act monies.

The combination of the proposed cuts in the Nurse Training Act and the Title V monies with the States' inability to assume increased funding of nurse-midwifery education leads to severe cuts in the Nation's annual output of certified nurse-midwives. As the record of the hearing on April 1, 1981, shows, nurse-midwives are a valuable asset to the health of women and infants in this country. Nurse-midwives are also a cost-effective tool in the Congressional efforts to care for mothers and babies who depend on the public sector for health care.

Thank you for adding this information to the official record of the hearing. If you have any questions, please feel free to contact the American College of Nurse-Midwives.

Sincerely,

SALLY AUSTEN TOM,
Government liaison.

Senator DURENBERGER. What are the licensure problems you have? I mean, are there some States in which nurse-midwives are not permitted to practice?

Ms. TOM. There is only one State in which nurse-midwifery appears to be restricted because of the legal situation, where we have a restrictive Attorney General's ruling on the Nurse Practice Act in that State.

Nurse-midwifery is not clearly illegal anywhere, and in all the rest of the States, as far as we are able to tell, nurse-midwives can practice fully, and in most they do.

Senator DURENBERGER. I thought when we got into the majority, these things weren't going to happen.

Dr. Duxbury, your testimony relative to opposition of the block grants, is your problem there with the administration's particular suggestions regarding blocks, or just with the concept of blocks? In other words, title V, at least to a degree, operates much like a block would operate anyway with not an awful lot of Federal involvement. Is it the problem that we're mixing maternal and child with other health areas that you object to?

Dr. DUXBURY. Yes. I think we would be competing with other important programs through block grants, but we are in an unfair position to compete. Children, fetus, babies don't vote, and I think when we get at the State level and we are competing with organized lobbies that are more effective than children are perhaps, we would lose the resources that must be allocated to maternal child health.

Senator DURENBERGER. Let me ask you a question about the research and training functions of title V. I think under the administration's proposal they would be carried out by NIH. What relationships have you had with NIH insofar as their support for this particular kind of research?

Dr. DUXBURY. Yes. I noticed the administration's rationale for the elimination of the research and training suggesting that funds are available for NIH. That has not been my experience and I think most nurse researchers in the country will attest to that. They do not fund applied, that is, immediately practical kind of research in maternal child health.

As far as nursing itself, I believe there are less than six nurse researchers on all of the study sections in NIH which administers over $3.5 billion.

Senator DURENBERGER. Thank you very much for your testimony.

[The statements of the preceding panel follow:]

STATEMENT OF MITZI DUXBURY

The American Nurses' Association has serious concerns about the consolidation of vital health services and the accompanying budget reductions as proposed by the Reagan Administration in its block grant recommendations. The ANA is particuarly concerned about the impact that these proposals will have on Maternal and Child Health care services provided under Title V of the Social Security Act.

A reduction in services provided through this program will ultimately contribute to higher health care costs by forcing patients to seek care from more costly acute care facilities.

Existing maternal and child health care programs have played a key role in reducing maternal and infant mortality and morbidity and in establishing improved methods of delivering care to low income mothers and children.

The ANA is seriously concerned with the Administration's proposal to eliminate clinical research and training in maternal and child health.

The American Nurses' Association, the professional organization of registered nurses in the United States, is deeply concerned with certain aspects of the Administration's current budget proposals. We recognize the need to reduce the Federal budget deficit and provide for more controls on spending. But this must not be done at the social cost of failing to care for those who are most in need and the least able to obtain health care services.

We have serious concerns about the consolidation of vital health services programs under block grants and the repeal of existing authorizing legislation, including Title V (Maternal and Child Health). The creation of the existing network of categorical health programs was prompted by the inability of many states to provide health services for certain high risk populations. Congress established and authorized these programs to deal with health problems which were national in scope. Categorical programs, such as maternal child health services, mental health services, and community and migrant health centers have effectively addressed the needs of high risk underserved and unserved populations. There is no current data to support the contention that the need for Federal focus and intervention on these national health problems has simply disappeared.

The consolidation of these health service programs would be accompanied by a substantial cut in Federal support. The Administration proposes a funding level for the block grants of 75 percent of the fiscal year 1981 funding levels. A 25-percent reduction would impact negatively on the availability of health services and ultimately contribute to higher health costs by forcing patients to seek care from more costly acute care facilities.

In addition, the consolidation of services into block grants would eliminate those quality control mechanisms which have been developed for categorical programs. There would be no way to establish national data on need, services provided, or their effectiveness in meeting national goals. Each state would have to develop and maintain its own administrative system for doing the work that is now done at the Federal level. Further, the block grant may lend itself to becoming a political tool within the states dominated by the most powerful interest groups at the state level. There is no guarantee that these grants would be used as intended.

REPEAL OF TITLE V

We have specific concerns about the block grant proposal as it relates to the repeal of Title V, Maternal and Child Health services. These programs have played a key role in reducing maternal and infant mortality and morbidity and in establishing improved methods of delivering health care to low income mothers and their children. Title V of the Social Security Act has helped create programs at the state and local level throughout the country to improve the health of mothers and children, particularly in areas with unserved and underserved populations. Priority is given to states with the highest infant mortality rates. It is obvious that future health care costs can be significantly reduced through the provision of comprehensive health care services to mothers and young children by preventing the development of serious illness and disabilities.

Services provided to states through ongoing projects funded through formula grants include: preventive health care such as prenatal and postpartum care to women, immunizations, vision and hearing screening and treatment services, and growth and development counseling for children.

Other Federally funded health programs are required to be administered in conjunction with Title V programs at the state level. These include: Sudden Infant Death Syndrome, Genetic Diseases, Hemophilia, and the Supplemental Security Income/Disabled Children's Program. Family planning services and adolescent pregnancy programs also have linkages with these delivery systems, in many states. Special projects are also funded under existing authority. Thirty-four Improved Pregnancy Outcome projects as well as other maternal and infant care projects are targeted to states with high incidents of infant mortality. Moreover, 13 Improved Child Health Delivery Systems projects are targeted to areas with excessive infant morbidity and mortality. The repeal of Title V of the Social Security Act would also be highly disruptive to other programs currently requiring linkage with Title V programs

Because certain maternal child health programs are regionalized block grants could disrupt or eliminate services provided to children and families. This would primarily affect the hemophilia program and the Pediatric Pulmonary Centers. For example, the hemophilia program based in Minnesota serves Minnesota, North Dakota, South Dakota, and parts of Wisconsin and Iowa. Another Minnesota based program in pediatric cardiology serves the same geographic areas.

In addition the service area of a Colorado based pediatric pulmonary center includes Wyoming, Utah, Nebraska, North and South Dakota which includes an

interdisciplinary team which visits all patients every three months and trains family physicians as well. These programs deal with low incidence disease, and it would not be cost effective for each state to have a separate program. It is highly questionable whether states would be willing to utilize the reduced funding allocated under a block grant to support programs that are used by other states.

Although maternal child health services are targeted to low income, high risk populations, many activities such as childbearing classes and prenatal care are open and utilized by the community at large. Coordination of services and the identification and referral to community resources, whether public or private, are usual and customary practices of the public health nurse, nurse-midwife, and school health nurse. Publications providing general health information about specific health problems for consumers as well as specific information for health care providers have wide distribution and are available to all upon request.

The decrease in services that will result from the President's budget request for these programs will adversely affect the general population.

CLINICAL TRAINING AND RESEARCH

A final major concern for nursing is the clinical training and research programs supported under Title V. The Administration has proposed a rescission of $6 million from fiscal year 1981 training and research programs, and recommends eliminating funding for these programs in fiscal year 1982. We oppose this proposal which would reduce training support for the current year by 25 percent and by 100 percent for the next fiscal year.

In the 1979-80 academic year, a total of 392 nurses received traineeships or tuition assistance for advanced study in maternal and child health areas; 341 of these were studying at the master's or post master's level. An additional 333 students attended these nursing programs without direct financial support. Title V training funds are primarily provided for institutional support thereby affording more nurses access to advanced study than could be possible if all monies were directed to traineeships alone. Less than 9 percent of all Title V funds are allocated to nursing programs directly.

The majority of Federal dollars are provided to programs which are interdisciplinary by design and which are focused on the service needs of a state or region. These programs emphasize clinical training in such area as: mental retardation, handicapped children, adolescent health, pediatric pulmonary problems such as cystic fibrosis and asthma, neonatal intensive care, and community based health care for mothers and children. Many of these programs, some of which are directly affiliated with a school of nursing, are likely to be dropped by their sponsoring institution if there is no Federal funding. Approximately 10 percent of the money allocated to these programs is for direct student support.

Funding for research under Title V currently supports 46 projects. Only those projects that demonstrate the practical application of research findings are funded. It is important to note that applied research in maternal and child health is not funded through any other existing Federal research program. Although the Administration has indicated that researchers in maternal and child health should compete for funding through the National Institutes of Health, applied research in the MCH area is not funded through NIH and non-basic science research has never been a high priority for funding in any field.

Elimination of Title V research funds would mean that research designed to influence the way services ae delivered to mothers and children would cease to exist. Priorities for maternal and child health research include: delivery of health care to mothers and children, habilitation and rehabilitation of handicapped children, needs of high risk mothers and infants, adolescent health, nutrition, and prenatal screening.

Special attention has been given to the followng areas: the consequences of illness of either the parent or child on the functioning of the family; the evaluation of intervention schemes involving children with developmental disabilties; the assessment of the value of new tehnologies as they are introduced in the Neonatal Intensive Care Units; and the processes of genetic counseling and psychological support in prenatal and neonatal screening for genetic and birth acquired conditions.

My own research, funded through Title V, has focused on the individual and organizational factors which contribute to absenteeism and turnover of nurses employed in neonatal intensive care units in the Minneapolis area. This research focuses on ways the health care system can deliver services more efficiently and effectively and is essential in my view.

Research and training efforts in maternal and child health require a Federal role in funding. It does not make sense to cut off funding for a program which although

relatively small, has made a significant impact on increasing supply of nurses with advanced education in the area of maternal and child health where shortages of trained personnel clearly exist.

Statement of the American College of Nurse-Midwives

Summary

1. A certified nurse-midwife is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives.
2. All certified nurse-midwives are nurses who have completed an accredited program of education in midwifery, six of which are funded by the Title V MCH Training monies.
3. Nurse-midwives have been in the U.S. since 1925 and have increased rapidly in the last twenty years because the federal government and childbearing families support nurse-midwifery care.
4. The federal government has a long history of support for nurse-midwifery education and practice and nurse-midwives are an integral part of many health care projects for the medically indigent.
5. Nurse-midwives have a demonstrated ability to reduce infant morbidity and mortality and improve pregnancy outcome.
6. Nurse-midwifery care has been shown to be cost effective for a variety of reasons.
7. Nurse-midwifery education programs are planning to become financially self-sufficient but will need further federal help; considerable physician resistance to expansion of nurse-midwifery services hinders these plans.
8. The American College of Nurse-Midwives is concerned that basic services to women and children not be reduced in conjunction with changes in funding mechanisms and offers recommendations for maintaining minimum levels of care for mothers and babies.

Good morning. My name is Sally Tom and I am a practicing certified nurse-midwife. I am representing the American College of Nurse-Midwives and am also speaking today from my experience as a nurse-midwife educator. I am on the faculty of Georgetown University's Graduate Nursing Program in the Growing Family, Nurse-Midwifery Specialty Area. In addition, I am a graduate of a nurse-midwifery edcuation program funded by Title V and have worked for or in close association with several MCH funded programs.

The American College of Nurse-Midwives (ACNM) is the professional organization of Certified Nurse-Midwives (CNMs) in the United States, representing 85 percent of all CNMs. The ACNM is autonomous from all other professional organizations and speaks for its membership on all issues affecting the practice, education, recognition, legislation and economics of nurse-midwifery. The ACNM collaborates with other professional groups which share its primary concern of quality maternal and infant health care for women and babies and is recognized as an advocate for maternal and child health care issues.

According to the official ACNM definition, "A certified nurse-midwife is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives. Nurse-midwivery practice is the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally and/or gynecologically. This occurs within a health care system which provides for medical consultation, collaborative management, and referral and is in accord with the 'Functions, Standards and Qualifications for Nurse-Midwivery Practice' as defined by the ACNM."

There are approximately 2,200 nurse-midwives in the United States and approximately 220 more graduate each year. Most nurse-midwives practice in association with institutions such as hospitals, clinics, and birthing centers. A small number offer home birth services. In 1976–1977, nurse-midwives did approximately one percent of all births in the U.S.[1]

Because among the many programs of concern in today's hearing are six nurse-midwifery education programs, I want to describe the educational route a nurse-midwife takes. The first step toward becoming a professional nurse-midwife in the United States is to study nursing, and then practice nursing in the field of maternal

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[1] Research and Statistics Committee of the American College of Nurse-Midwives, Nurse-Midwifery in the United States: 1976–1977. (The American College of Nurse-Midwives, Washington, D.C., 1978.)

and infant health for at least one year. The future nurse-midwife then applies to a nurse-midwifery educational program. Although all of these programs are associated with major universities, some are part of a Master's Degree program, and others grant a certificate rather than a degree. Both kinds of programs offer nurse-midwifery education which prepares the student nurse-midwife for clinical practice. Students in Master's programs also receive further education in public health or nursing. Students who successfully complete their educational programs are eligible to take the American College of Nurse-Midwives' certification examination. Those who pass the examination are certified as nurse-midwives-CNMs. All nurse-midwifery programs are accredited by the Division of Accreditation of the ACNM.

Until the last decades of the 19th century, childbirth was in the hands of women. Midwives practiced an art and science passed from woman to woman. Mothers gave birth at home, surrounded by female friends and relatives, attended by a midwife who usually was also a friend or relative. A number of factors, including the rise of the medical profession, the growth of the public health movement, a trend toward limiting family size, the political vulnerability of midwives and their clients, the high infant and maternal mortality rates, and the severe decrease of immigration during and after World War I, combined to virtually eliminate traditional birth attendants and to move birth from the home to the hospital by the early 1900s.

Maternal and child health became a national political issue when, during World War I, one third of all men were found physically unfit for military service and one half of those were thought to have suffered from poor maternal and child care. This experience during World War I and the political strength of newly enfranchised women brought about the passage of the Sheppard-Towner Act in 1921, creating the first infusion of federal dollars into maternal and child health care.

In 1925, Mary Breckinridge, an American nurse educated in midwifery in England, established the Kentucky Committee for Mothers and Babies. A native Kentuckian, Mary Breckinridge became the country's first nurse-midwife and the committee became the Frontier Nursing Service, providing care for mothers and babies in mountainous, isolated Eastern Kentucky. Like the earlier midwives, nurse-midwives support the natural processes of healthy birth with watchful expectancy and emotional support. Unlike the midwife of past centuries, the certified nurse-midwife comes to her work after rigorous education offered by prestigious universities, bringing a scientific basis to her practice and an ability to identify and respond to deviations from the normal course of childbearing.

The number of nurse-midwives increased slowly between 1931, when the Maternity Center Association in New York opened the first nurse-midwifery education program, and 1970. By 1970, approximately 600 people had graduated from U.S. schools of nurse-midwifery. In the last 10 years the number of schools has doubled to more than 20 and an additional 1,600 nurse-midwives have graduated. The recent rapid growth of nurse-midwifery is a response to both the desire of mothers and their families for nurse-midwifery care and to federal support for nurse-midwifery. Families want care which offers them decisionmaking power and reasonable options in childbearing. Meticulous screening throughout pregnancy and birth, combined with freely shared information and continuity of care, are the hallmarks of nurse-midwifery care.

The traditional constitutents of the certified nurse-midwives are women and children who live in poverty in both rural and urban areas. Only since the 1970's have professional midwifery services, which have long been available to women of all classes in other countries, been available to economically affluent women in the United States. Nurse-midwives are responding to increasing demands for nurse-midwifery care from affluent women by participating in a variety of private sector settings.

The federal government has a long history of support for nurse-midwifery. Several federal agencies rely heavily on nurse-midwives to provide care in their programs—the Indian Health Service, Rural Health Clinics, the Maternal and Infant Care Projects, the National Health Service Corps, Improved Pregnancy Outcome projects, Adolescent Pregnancy Projects, and the Army, Air Force and Navy. Nurse-midwives receive direct reimbursement for services to military families under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Medicaid.

Several recent federal government reports support nurse-midwifery practice. The Graduate Medical Education Advisory Committee's report recommended that nurse-midwifes be doing 5 percent of all normal deliveries in the United States by 1990 and that federal support for nurse-midwifery education remain at its current level.[2] The current output of educational programs is not sufficient, however, to meet that

[2] Graduate Medical Education National Advisory Committee Report (DHEW, Washington, D.C.: 1980).

goal. The report on necessary maternal and infant health services prepared for the Select Panel for the promotion of Child Health focuses on nurse-midwifery services.[3]

The General Accounting Office's report, "Better Management and More Resources Needed To Strengthen Federal Efforts To Improve Pregnancy Outcome" describes nurse-midwives' effectiveness in delivering care to low income families. The report observes that "although HEW has endorsed use of nurse-midwives, the Health Services Administration has not aggressively promoted use of nurse-midwives in its programs."

The GAO recommended that ". . . HEW encourage a greater use of nurse-midwife obstetrician teams, help eliminate barriers which preclude nurse-midwives from practicing in hospitals, and provide additional training funds for nurse-midwives, by giving such training higher priority for use of existing funds and/or seeking additional funds from Congress."[4] HEW agreed that better training and practice opportunities are needed for nurse-midwives and promised to convene a working group of HEW operating agencies to develop by March 1980 a plan to promote greater use of nurse-midwives. This plan has not yet been developed; however, the working group has held one meeting and two consultations with nurse-midwives.

The safety of nurse-midwifery care has been well established. At a hearing held December 18, 1980, by the Subcommittee on Oversight and Investigation of the Interstate and Foreign Commerce Committee, noted epidemiologist, C. Arden Miller said, "All of the studies I know confirm that the health benefits of care as rendered by nurse-midwives stand up to scientific scrutiny exceedingly well." He added that many of the interventions routinely used in obstetrics today have been subjected to a scientific scrutiny which ". . . is in many respects less rigorous than the scrutiny to which the midwife's services are subjected."[5] A considerable body of research documents the safety of nurse-midwifery care. All studies have shown that the risk to women attended by nurse-midwives is equal to or lower than the risk to comparable groups of women attended by physicians. In fact, the literature reports instances of striking reductions in infant mortality rates after introduction of nurse-midwifery care.

Since its beginning in eastern Kentucky, nurse-midwifery care has been introduced to other medically underserved areas characterized by poverty, geographical isolation and other social factors associated with poor obstetrical outcomes. Nurse-midwives screen carefully for indications of medical problems and collaborate closely with physicians when complications arise, thus identifying clients who are essentially medically normal from among the population characterized by social risk factors. Nurse-midwifery care has been shown to increase utilization of prenatal care, lower infant mortality and morbidity and to increase maternal well-being among these populations.

At the Frontier Nursing Service ". . . the maternal mortality rates averaged 9.1 per 10,000 births from 1925–1951; among white women nationwide the maternal mortality rate was 34 per 10,000. Since 1951, the FNS has not lost a single mother to birth related causes. FNS neonatal mortality rates in the years 1952–1954 were 17.3 per 1,000—less than the rest of Kentucky and the United States. Since 1971 the FNS perinatal mortality rates have averaged only 6 per 1,000 which is less than half the average of the rest of the country, even in its best year (14.5 in 1977), and better than the best country in the world, Sweden. The Metropolitan Life Insurance Company of New York estimated in a report in 1932 that if services like the FNS were adopted nationwide, the perinatal mortalities of the time would be reduced by 60,000 per year.[6]

Nurse-midwifery services in other rural areas, especially in the South and Southwest, have produced similar improvements in pregnancy outcome. The Medical Mission Sisters founded the Catholic Maternity Institute in 1943 to serve the impoverished mothers of Santa Fe County, New Mexico. The Sisters offered prenatal care and birth at their Childbearing Center. Many births also took place in adobe homes with no electricity or running water. Prior to the program, in 1939, perinatal death rate of Santa Fe County were 87.6 per 1,000. By 1967 it had been reduced to 15.1, a

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[3] S. Kessel, J. Rooks, I. Cushner, "A Child's Beginning," Report Prepared for the Select Panel for the Promotion of Child Health (DHEW, Washington, D.C.: October 1980).

[4] General Accounting Office, "Better Management and More Resources Needed To Strengthen Federal Efforts to Improve Pregnancy Outcome," (General Accounting Office, Washington, D.C.: 1979).

[5] C. Arden Miller, M.D., Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., Dec. 18, 1980.

[6] D. Stewart, "The Five Standards for Safe Childbearing" (NAPSAC Productions, Marble Hill, Mo., anticipated publication spring 1981), p. 109.

level of achievement not to be attained by the country at large until over 10 years later. At that time, in 1967, the perinatal mortality rates of the United States were 22.1 per 1,000, while in New Mexico it was even higher at 24.8. . ." [7]

In the early 1960's a CNM practice was established as a pilot project in Madera County, California. Special legislation made nurse-midwifery legal for the duration of the project. Certified nurse-midwives were introduced as the only new variable in the medically understaffed county's health care system. The mothers served by the project were primarily agricultural workers.

During the first 18 months of the project, the Madera County prematurity rate dropped from its previous level of eleven percent to 6.6 percent and the neonatal mortality rate dropped from 23.9 deaths per 1,000 live births to 10.3 deaths per 1,000 live births. There was a significant increase in attendance at prenatal clinics during the pilot project. Mothers who had had no prenatal care and who were cared for during labor and delivery by nurse-midwives experienced a neonatal death rate of 26.8 per 1,000 live births. The neonatal death rate for mothers who had no prenatal care was 50.6 per 1,000 live births after the project ended and nurse-midwifery care during labor was no longer available.

Despite these good results, the California Medical Society opposed legalization of nurse-midwifery and the nurse-midwives had to leave at the end of the project. After they left, the prematurity rate increased by almost 50 percent and the neonatal death rate tripled.[8]

In Holmes County, Mississippi, in 1971 the infant mortality rates had dropped from approximately 39 per 1,000 live births to 20 per 1,000 live births, two years after certified nurse-midwives began providing primary care to pregnant women as part of a community-wide focus on the health problems of mothers and babies.[9]

A study by the University of Mississippi Medical Center between October 1, 1971, and April 30, 1973, showed that nurse-midwifery clients kept 94 percent of scheduled appointments, compared with 80 percent of visits kept by clients of the house staff physicians. It should be noted that clients of both physicians and nurse-midwives did not see the same care providers at successive visits.

Among the nurse-midwifery clients 82.6 percent had normal spontaneous vaginal deliveries; 62.1 percent of the house staff clients had normal spontaneous deliveries, with most of the difference found in the rate of low forcep deliveries by the house staff.[10]

At Su Clinica Familiar, a nurse-midwifery childbirth center in southern Texas, all maternity care for normal mothers is provided by certified nurse-midwives. The prematurity rate in 1974, two years after nurse-midwifery began, was 3.5 percent. In the same year in Texas the prematurity rate was 7.6 percent and for the nation it was 7.4 percent. The nurse-midwifery service has been operating since 1972. The clients are Mexican-American and Mexican women who are primarily migrant workers.[11]

"In 1976 a nurse-midwifery program was begun in Mississippi County in northeast Arkansas. In 1975, 80 percent of births had occurred under general anesthesia in that county. In 1979 general anesthesia rates had fallen to 12 percent, while perinatal mortalities also dropped dramatically.[12]

"In 1941 the Tuskegee School of Nurse-Midwifery opened in Alabama offering services to the area. During the five years of its existence, neonatal mortality rates went from 46 per 1,000 live births to 14—more than a three-fold improvement." [13]

Nurse-midwifery services have also resulted in lowered infant mortality and morbidity rates among inner-city mothers.

In 1931, the Maternity Center Association (MCA) opened the Lobenstine Midwifery Clinic to care for immigrant families in upper Manhattan tenements. Between 1931 and 1951, 5,765 mothers registered with the clinic, of which 87 percent gave birth at home attended by (nurse-)midwives. Their maternal mortalities were less than one-third the national rates of the time. Their average neonatal death rates were only 15 per 1,000 while that of New York City as a whole ranged from 28.0 in

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[7] Ibid., p. 109.

[8] Barry S. Levy, Frederick S. Wilkinson and William M. Marine, "Reducing Neonatal Mortality Rate with Nurse-Midwives," *American Journal of Obstetrics and Gynecology,* 109 (Jan. 1, 1971): 51-58.

[9] Marie C. Meglen, "A Prototype of Health Services for Quality of Life in a Rural County," Bulletin of Nurse-Midwifery, XVII, No. 4 (November 1972): 103-113.

[10] C. Slone, H. Wetherbee, M. Daly, K. Christensen, M. Meglen, and H. Theide, "Effectiveness of Certified Nurse-Midwives," *American Journal of Obstetrics and Gynecology,* 124 (Jan. 15, 1976): 177-182.

[11] Sr. Angela Murdaugh, "Experiences of a New Migrant Health Clinic," Women and Health, Vol. 1, No. 6 (November-December, 1976): 25-28.

[12] D. Stewart, op. cit. p. 112.

[13] Ibid., p. 111.

1931 to 18.4 in 1951." Kings County Hospital, New York City, opened a nurse-midwifery service in 1976. In the first 884 births, they had a neonatal mortality rate of 7.9 per 1,000, reflecting the deaths of 7 premature babies.[14]

At the North Central Bronx Hospital, whose clients come from one of New York's most distressed areas, where every patient receives nursing care or nurse-midwifery management from nurse-midwives in labor, from January 1 to December 31, 1979, 88 percent of the mothers experienced normal spontaneous vaginal deliveries. Less than 30 percent of all mothers needed analgesia or anesthesia in labor. The neonatal death rate among infants 1,000 grams or over was 4.2 per 1,000.[15]

Since 1970, nurse-midwifery practice in the United States has expanded to include two additional special populations, adolescents and economically affluent women. Adolescent childbearing carries social and medical risks which can often lead to poor obstetrical outcomes. Nurse-midwifery care, along with physician collaboration has been effective, and has been shown to improve the outcomes of teenage pregnancy.

Between 1976 and 1977 at a clinic for teenagers in Lincoln Hospital in New York City, nurse-midwifery care brought considerable improvement in outcome measures such as maternal weight gain and hematocrit. The rate of low birth-weight babies dropped from 18.1 percent to 6.3 percent.[16] The Office of Adolescent Pregnancy at the Department of Health and Human Services has stressed inclusion of nurse-midwifery services in the projects it funds.

The first part of this testimony documents the safety and high quality of nurse-midwifery care. I would like now to open a discussion with the committee about how Congress can pursue its goal of providing maternal and child health care in a cost-effective way. The available data suggest that nurse-midwifery care is generally less expensive than traditional obstetrical care.

A study conducted in rural Georgia showed significant improvement in infant outcomes and a decrease in health care expenditures after introduction of nurse-midwifery care.[17]

Nurse-midwifery care often opens the door to lowered costs through the use of non-hospital facilities, such as a birth center or the client's home, for normal births. The Blue Cross/Blue Shield of Greater New York audited the Childbearing Center started by the Maternity Center Association in New York City in 1976-1977. They found that care at the Childbearing Center cost 37.6 percent of in-hospital care, barring complications. The report also stated that the cost to Blue Cross/Blue Shield of Greater New York for families delivering at the Center was 66.1 percent of the cost to the plan had the family gone to the hospital, barring complications.

The cost to the health care system of full care at the Center has decreased each year, from a high in 1976 of $2,016.46 to $1,046.17 in 1979 as utilization increased. The Childbearing Center staff expect the Center to be self-supporting with 600 families in the program annually. In late 1980 the Center had over 500 families enrolled and expected to meet their goal very shortly.

Medicaid is currently paying from $1,649.53 to $2,230.04 for normal care with a three-day hospital stay in various New York hospitals. The Childbearing Center currently charges $1,000 for its whole package of prenatal, intrapartum and postpartum care; the Center receives $885 for total care from Medicaid and the Center is appealing that rate.

The care at the Center is economical because clients have the opportunity for prolonged contact with professionals, including the nurse-midwives who are with them in labor and delivery. A client's stay at the Center is much shorter than the typical three-day stay and she receives intensive, personalized care during that time.

The Center is also economical because non-hospital facilities, the Center and the client's homes are used as settings for provision of care. The Center's all inclusive fee of $1,000 compares favorably with the $3,000 for hospital and obstetric fees which private care in New York City can cost.[18]

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[14] Ibid., p. 115.

[15] Doris Haire, "Improving the Outcome of Pregnancy Through the Increased Utilization of Midwives During Labor and Delivery," Testimony to the Mayor's Blue Ribbon Commission on Infant Mortality, February 14, 1980, Washington, D.C.

[16] M. Brenda Doyle and Mary V. Widhalm, "Midwifing the Adolescents at Lincoln Hospital's Teen-Age Clinics," *Journal of Nurse-Midwifery*, Vol. 24, No. 4 (July-August 1979): 27-32.

[17] Michael L. Reid and Jeffrey B. Morris, "Perinatal Care and Cost Effectiveness: Changes in Health Expenditures and Birth Outcome Following the Establishment of Nurse-Midwife Program," Medical Care, 5, Vol. XVII, (May 1979): 491-500.

[18] Ruth W. Lubic, CNM, Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., Dec. 18, 1980.

Another mechanism often associated with cost savings and midwifery care is the shortened hospital stay for a healthy mother and baby. Midwifery care during pregnancy and availability by phone or home visit during the early postpartum period set the stage for the well-prepared family to go home within 12 to 24 hours after a normal labor and birth.

In Washington, D.C., the current cost of prenatal, delivery and postpartum care with a nurse-midwifery service is $800 for each client planning to deliver in the hospital. This includes prenatal care, labor management and delivery, postpartum care, a two week, six week, six months and one year checkup and three postpartum classes. Physician's fees vary from $800 to $1,200 and include prenatal care, labor and delivery management, postpartum care, and a six weeks check-up. Hospital costs for nurse-midwifery clients who spend 6 hours or less in the hospital after delivering are around $600 for each woman. Clients who stay the traditional three days will pay close to $1,000 in hospital costs.

Most nurse-midwives are employees who have no control over prices charged to clients. As more nurse-midwives go into practice with physicians and establish private nurse-midwifery practices, we will begin to be able to assess the financial impact of private nurse-midwifery practice. CHAMPUS began reimbursing nurse-midwives within the past year and is conducting a study of the impact of nurse-midwifery reimbursement on their maternity care costs.

While the data are limited, several characteristics of nurse-midwifery practice suggest that nurse-midwives deliver cost-effective care. The average salary of a nurse-midwife in clinical practice in 1976 was $16,200. Contrast this figure, which has certainly improved somewhat since 1976, with the median income of any obstetrician-gynecologist, which was $89,310 in 1979. Nurse-midwives' services have to cost employing institutions less than obstetricians'.

As we have seen earlier, nurse-midwives have a proven record in reducing infant morbidity and mortality. The reduction in prematurity and low birth weight rates in the many places nurse-midwives have worked certainly must also have meant a reduction in dollars spent by states and private companies on intensive care nurseries. An official of the University of Mississippi, Peter H. Meyers, has compared the taxpayers' cost for nurse-midwifery education with the savings reaped through improved pregnancy outcomes.[19]

Looking at 76 graduates over a three-year period, I found their median age to be 31. Assuming that on the average 75 percent of them work until age 65, delivering 15 babies per month and referring 5 others, I can anticipate that they will provide primary care for 583,680 mothers, delivering 437,760 babies.

Using a very conservative cost for lifetime institutionalization of $500,000 we can say that if only 4 out of 583,680 babies have radically different outcome (family support rather than lifetime institutionalization) the taxpayer breaks even. The break-even point is reached if fewer than 1/1000 of 1 percent (.0000068) of "our" babies avoid lifetime institutionalization. I would, more realistically I believe, predict a savings to taxpayers of many hundreds of times the program's cost.

Cost effectiveness includes other costs such as the cost of delivering care, and the cost of nursing school; but these costs are often borne in large measure or entirely by private parties.

None of this deals with maternal or infant mortality or maternal morbidity. What are the social costs when a mother dies? How often do her children become temporary or permanent wards of the state? What does that cost the taxpayer? I can't even guess.

Nurse-midwives are educated to use technology only when it is indicated by a client's condition. Such limited, rather than routine, use of machines and laboratory tests should result in savings for individual customers. Nurse-midwifery clients often use less analgesia or anesthesia in labor.

A Cesarean birth can add as much as $1,000 to a physician's fee and as much as $3,000 to hospital fees. Nurse-midwifery services have Cesarean birth rates which are significantly lower than the U.S. rate which is approaching 30 percent in many facilities. The Cesarean birth rate at the nurse-midwifery service at the North Central Bronx was approximately 13 percent in 1979, for example.

A nurse-midwifery service would be less expensive for the federal government to establish than a physician's practice because nurse-midwives need less complicated equipment. They need only to have access to high technology through their collaborating physician.

In addition to potential cost savings, nurse-midwives bring to each birth a concern for the psychological and cultural factors which affect the birth experience of the mother, family and infant. Ample research has shown that the nature of the birth

[19] Peter M. Meyers, University of Mississippi Medical Center, personal correspondence.

and immediate post-birth experience have a strong impact on later infant-parent relationships. The evidence suggests that positive birth experiences correlate with lower incidences of child neglect and abuse. Nurse-midwives strive to help parents create positive birth experiences and this must make an indirect contribution to lowered financial and emotional costs to society as a whole.

The information available and the logical conclusions drawn from examination of nurse-midwifery practice prove that nurse-midwifery care is a cost-effective means to providing safe, satisfying maternal and child health care.

An investment in nurse-midwifery education is then, one which brings good returns to Congress and to American families.

Most nurse-midwifery education programs are currently strongly dependent on Federal funding. Six programs receive Maternal and Child Health Training monies, the University of Utah, Johns Hopkins University, University of Mississippi, Columbia University, Emory University and the University of Illinois.

Several programs have estimated that if Federal funding were withdrawn, tuition would have to rise to between $22,000 to $30,000 to compensate. Banks would hesitate to give loans for such high tuition because nurse-midwives' salaries do not make them attractive loan candidates. Other student aid resources are not sufficient to cover student needs for current tuition costs; it seems unlikely student aid funds would increase in proportion to tuition increases.

If Federal funds are removed and not replaced by the States, the numbers of students admitted each year will be sharply reduced, the Nation's total yearly output of nurse-midwives will be severely reduced, services created by educational programs will be reduced or closed, care to indigent populations will be less available and costs will surely rise.

Nurse-midwives are valuable enough to the Nation that a Federal priority to continue educating nurse-midwives and to increase their utilization should be established.

All of us in nurse-midwifery education are aware of the need for dependable funding sources. Directors and faculties of nurse-midwifery education programs are devising strategies for shifting their funding base from soft money to hard money. All faculties would like to be fully supported on hard money by their universities, as are the programs at St. Louis University and University of Kentucky. Since most university budgets will not permit that kind of full support, nurse-midwifery educational programs are turning to developing self-supporting nurse-midwifery services as a means of finding financial support and clinical experience for students.

Nurse-midwifery education lends itself easily to this model because nurse-midwifery is largely taught in the clinic and at the bedside. Faculty must practice in order to teach nurse-midwifery; these same faculty, with accompanying students, could be reimbursed either through Medicaid or through private insurance plans. A faculty which had a practice large enough to offer students the necessary clinical experiences would be supplying a substantial part of its own salary. The university would then fund the non-clinical teaching activities, such as conducting seminars, curriculum revising, student counseling and program administration.

Financing nurse-midwifery education through private faculty practice is a concept which many programs are exploring. There is, however, a tension between the need to shift the funding base and the political reality of opposition to nurse-midwifery practice.

Among the six obstacles to greater Federal utilization of certified nurse-midwives which the GAO report identifies, the limited supply, few training programs, reluctance of some nurse-midwives to practice in less desirable areas, restrictive State; licensing or third party reimbursement, non-availability of obstetricians with whom to work, physician resistance is the most difficult problem.[20] This problem was recently the subject of an investigatory hearing held by the Subcommittee on Oversight and Investigation of the House of Representatives' Energy and Commerce Committee.

The resistance occurs despite the demand for nurse-midwives by consumers, State governments and Federal agencies, despite the record of improved health for mothers and babies, despite cost effectiveness and despite the widespread employment of nurse-midwives through the country. Resistance to nurse-midwifery practice is strong and seems to be gathering strength.

While I am describing this resistance in some detail, I hope you will keep in mind the co-existing reality that in many communities nurse-midwives, physicians and hospitals have formed mutually satisfying professional relationships. The ACNM and the American College of Obstetricians and Gynecologists (ACOG) often work together on issues of importance to mothers and babies. Nurse-midwifery practice

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[20] G.A.O., op. cit.

was officially endorsed by the American College of Obstetricians and Gynecologists (ACOG) and the Nurses Association of the American College of Obstetricians and Gynecologists in a statement issued jointly with the ACNM in 1971 and in a supplemental statement in 1975. The ACNM has benefited from and appreciated ACOG's official support.

The incidence of resistance is widespread and has been found in recent months in Massachusetts, New York, New Jersey, Pennsylvania, Washington, D.C., Maryland, Delaware, South Carolina, Tennessee, Illinois, and South Dakota. Resistance comes from many sources: individual physicians, professional organizations such as medical societies, hospital department of obstetrics, public bodies such as State boards of health and State medical practice boards, insurance companies, and occasionally nursing.

The form which the resistance takes varies as well. It includes refusal to provide medical collaboration, refusal of permission or privileges for use of hospital facilities, placement of unjustifiable restrictions on nurse-midwifery practice or settings, refusal of third party payors to reimburse nurse-midwives, harassment of physicians who support nurse-midwifery practice, request for unreasonable payments for liability insurance and misrepresentation of the nature of nurse-midwifery practice to the public.

In Washington, D.C., Georgetown University Medical Center has consistently refused to allow nurse-midwives to practice in labor and delivery, even though the school of nursing has had a nurse-midwifery education program for several years.

In New Jersey the Board of Medical Examiners has issued regulations which restrict nurse-midwifery practice and which prohibit nurse-midwives from caring for women under 16 and over 35 years of age. These regulations have a severe impact on nurse-midwives and their clients, expecially adolescents, in New Jersey.

In Nashville, Tennessee the two nurse-midwife members of an obstetrician-nurse-midwife team were denied privileges at three hospitals in which their physician practiced. Their physician experienced such strong harassment from his colleagues, including cancellation of his insurance by the physician owned malpractice insurance company, that he has left Tennessee. No other physician in Nashville is willing to collaborate with nurse-midwives in private practice. The nurse-midwives have been forced to close their business and undertake expensive legal action. They will be filing suit in a few weeks.[21]

When Maternity Center Association in New York City opened its Childbearing Center, an out of hospital birth center, they did so despite the opposition of a wide array of State agencies, State physicians' organizations and national physicians' organizations.[22]

In Englewood, N.J., the Childbirth Center has struggled to survive in the face of opposition from local physicians, the Board of Medical Examiners and a major insurance company.[23]

In Washington, D.C., a private group practice of three nurse-midwives who do home births embarked a year ago on a pilot experiment doing hospital births at the Washington Hospital Center. In order to obtain privileges the nurse-midwives became technically the employees of their collaborating physicians who already had privileges. Although the first year went well, the hospital's Department of Obstetrics and Gynecology voted to end the nurse-midwives' privileges because they are also doing home births. The decision has not been carried through by the hospital's board of directors becauce of the large public outcry against the decision. The department of Obstetrics has formed a committee to review the nurse-midwives' charts. There are no nurse-midwives or pediatricians on the committee.[24]

While scores of rationales for these obstacles exist, and each incident is flavored with its own particular legal, administrative and interpersonal characteristics, two themes emerge from the arguments against nurse-midwifery practice. The first of these is the issue of quality of care and of patient safety. The rare, and often preventable occurrence of a complication of pregnancy or birth if often cited as the reason for preventing nurse-midwives from practicing or for limiting the scope of their practice to less than that for which they have been educated. Two assumptions

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[21] Susan J. Sizemore, CNM, Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., Dec. 18, 1980.

[22] Ruth W. Lubic, CNM, op. cit.

[23] Lonnie H. Morris, CNM, Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., Dec. 18, 1980.

[24] Marion McCartney, CNM, Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., Dec. 18, 1980.

underlie that rationale. The first is the idea that while nurse-midwives are better than no prenatal or intrapartum care at all, the physician is always more desirable because of his or her education in dealing with complications. The statistics refute that claim. The record of nurse-midwifery care in the United States in reducing infant mortality and morbidity shows that nurse-midwives are safe. Countries with lower infant mortality rates than the United States' rely heavily on professional midwives.

The second underlying assumption is that the speed with which severe complications arise is great enough to justify physician presence throughout labor and delivery managed by nurse-midwives. It is important to remember that pregnancy and childbirth are normal physiological practices. Normal, healthy pregnancy and delivery are the predominant realities of childbearing. Complications are the exceptions, not the rule. Nurse-midwives, unlike most physicians, are able to be in constant attention throughout labor. Thus, nurse-midwives detect problems at the earliest moment and often avert them. Extremely serious complications which develop rapidly are extremely rare. Many common complications of labor and delivery result from the routine interventions of traditional medical care which do not characterize routine nurse-midwifery care. Nurse-midwives are educated to recognize the symptoms of complications, to begin the appropriate interventions and to call for assistance immediately when complications arise.

The second theme which emerges in the resistance of nurse-midwifery practices is that of "independent practice." Licensure, direct third party reimbursement, home birth services and out-of-hospital birth centers all raise the question of whether nurse-midwives are, or should be, "independent practitioners." "Independent practice" appears to mean a nurse-midwife hanging up her shingle in a solo practice patterned after the independent business of the solo physician in private practice. The implication of this model is that the nurse-midwife would be practicing without back-up physician, without the system for consultation with physicians, referral of clients to physicians and without the collaborative management of client care by both a nurse-midwife and a physician which are an integral part of the definition of nurse-midwifery practice. The record needs to be very clear on this matter. Nurse-midwives do not practice midwifery in the "independent practice" model of the private solo practice which characterizes much physician practice. The "Functions, Standards and Qualifications for Nurse-Midwifery Practice" states that the nurse-midwifery practice "Occurs interpendently within a health care delivery system. Occurs within a formal written alliance with an obstetrician; or another physician, or a group of physicians, who has/have a formal consultative arrangement with an obstetrician-gynecologist; exists within a framework of medically approved protocols."[25]

The dictates of the "Functions, Standards and Qualifications for Nurse-Midwifery Practice" are clearly explained by Helen Varney, the current president of the American College of Nurse-Midwives in her recently released textbook of nurse-midwifery. "' Independent management' refers to the fact that a patient may never see a physician if her course essentially is normal and she is managed by a nurse-midwife. Thus, the practice of nurse-midwifery within the protocols for practice, which define the practice and provide for medical consultation and referral is independent . . . Independent practice means without medical protocols of formalized physician back-up. A certified nurse-midwife always functions within a health care system in a team relationship with a physician and is never independent of physician back-up for consultation, collaborative management, or referral."[26] Should a nurse-midwife be thought to be violating the principles established in "Functions, Standards and Qualifications," she would be subject to investigation by the American College of Nurse-Midwives and would be vulnerable to censure, suspension, expulsion or decertification.

Nurse-midwives have always practiced and will continue to practice in collaboration with physicians; that relationship will not change. What has begun to change, however, is the employment relationship between the nurse-midwife and her collaborating physician. Nurse-midwives are now not always employees of physicians or hospitals. In some cases the nurse-midwife has joined the practice of her physician partners. In other cases, nurse-midwives are employing physicians to provide them with consultation and referral services. Nurse-midwives are increasingly eligible for direct third-party reimbursement. Many private insurance companies including Connecticut General, Travelers, Aetna, and all union insurance programs, will reimburse nurse-midwives in all states. New Mexico, Utah and Maryland have

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[25] American College of Nurse-Midwives, "Functions, Standards and Qualifications for Nurse-Midwifery Practice" Washington, D.C., 1975.

[26] Helen Varney, CNM, Nurse-Midwifery (The C.V. Mosby Company, St. Louis, Mo., 1980).

adjusted their insurance codes to include direct reimbursement to nurse-midwives. CHAMPUS and Medicaid now reimburse nurse-midwives. All of these changes mean there is substantially more competition in the obstetrical market place. All of these changes mean that a nurse-midwife may become economically independent of her physician or hospital back-up services. Her professional interdependence with physicians and hospitals remains and always will.

Until nurse-midwives are able to establish self-supporting faculty practice arrangements which put education programs on dependable, renewable financial bases, nurse-midwifery education programs will need federal aid.

Until this country no longer has citizens who lack access to maternal and child health care and to safe options in maternity care, the federal government will need nurse-midwives.

Nurse-midwifery services provide the federal government with a safety net upon which to depend in a time of budget cuts. Certified nurse-midwives are in part an antidote to the high cost of federal maternal and infant health care. Funds invested in nurse-midwifery education are moneys prudently invested and many times returned.

RECOMMENDATIONS

Many facets of the Maternal and Child Health programs were established in an era which differs greatly, both economically and medically, from our current situation. There still are, however, mothers and babies who are urgently in need of primary health care. The American College of Nurse-Midwives is concerned that, in the midst of attempting to put our national economic house in order, minimum, binding, national guidelines be developed to accompany funding mechanisms for maternal and child health programs. These guidelines should stipulate the following measures described below.

1. States must maintain basic services for prenatal, labor and delivery, post partum, newborn in-patient care, well baby care, minimum levels for well child pediatric care and family planning services.
2. States must find ways to decrease costs by using low technology health care rather than high technology care, where appropriate.
3. States must expand the use of non-physician health care providers, such as nurse-midwives, as a strategy for lowering costs while maintaining high quality of care or improving on the care available.
4. The federal government and the states develop mechanisms to continue funding of nurse-midwifery education programs, such as regional funding and regional development of clinical practice and education sites in underserved areas.
5. The federal government and the states begin planning now to gather the data necessary to measure the impact of changes in each state's programs and funding mechanisms on health care costs and health care programs.

The American College of Nurse-Midwives is pleased to have been asked to testify today before the Senate Finance Committee. The members of the College look forward to working with you in your efforts on behalf of mothers and babies in the United States.

Senator DURENBERGER. I am going to have to recess the hearing then for approximately 7 minutes with apologies to the next panel, particularly to the last panel.

We'll be right back.

[Rollcall vote 10:30 a.m. to 10:45 a.m.]

Senator DURENBERGER. We will call the meeting back to order. I apologize. I think I said 7 minutes, but I got trapped by somebody out there who said that the chairman of the Health Subcommittee should not be drinking coffee and smoking a pipe, so they made me walk over to the Capitol.

We will next introduce a panel consisting of Dr. Judson Force, State of Maryland; Dr. Richard P. Nelson from the State of Minnesota; Dr. Bob Goldenberg, State of Alabama; Dr. Gerold Schiebler from Florida who is going to be introduced by his senior Senator, Lawton Chiles, who is with us; Dr. Pat Schloesser from Kansas and Mr. Vernon Smith who is the director of the Bureau of Medicaid Information and Policy Development in Lansing, Mich.

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I welcome you all, and, Lawton, if you would do us the honor of telling us why you think enough of Dr. Schiebler to be here today.

INTRODUCTION OF DR. GEROLD L. SCHIEBLER BY SENATOR LAWTON CHILES OF FLORIDA

Senator CHILES. Thank you very much, Mr. Chairman and Senator Bentsen.

I am pleased to introduce Dr. Gerry Schiebler, the chairman of the department of pediatrics of the University of Florida. He is one of our leaders in child health in the State of Florida and he was instrumental in setting up our State's highly acclaimed children's medical services program; and the aim of that program is to provide all children in Florida with comprehensive health care.

I think that comprehensive system can be taken as a first-rate working model for other States and the Federal Government.

I also want to take this opportunity, Mr. Chairman, to congratulate you on moving ahead with these hearings on child health care. It has been clear to several of us that the current medicaid child health program, early periodic screening, diagnosis and treatment (EPSDT) has not been working. My personal feeling of the situation is that there has not been a serious attempt to bring programs which develop the service delivery system together with a fee-for-service entitlement of medicaid.

I understand you are going to be exploring these problems with a series of hearings, and I certainly wish you a great success.

I know Dr. Schiebler will bring you the value of his expertise and experience and the experience that we have had in Florida; and so I leave you in his care.

Senator DURENBERGER. Thank you very much, Lawton.

Senator CHILES. Thank you.

Senator DURENBERGER. We will either proceed in the order that I introduced you all, or unless you have caucused ahead of time and decided on some other order, Dr. Force, you are the first witness.

STATEMENTS OF JUDSON FORCE, M.D., CHIEF, DIVISION OF CRIPPLED CHILDREN'S SERVICES, MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES ADMINISTRATION, STATE OF MARYLAND; PRESIDENT, ASSOCIATION OF STATE MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES DIRECTORS, BALTIMORE, MD.; RICHARD P. NELSON, M.D., DIRECTOR, SERVICES FOR CHILDREN WITH HANDICAPS, MINNEAPOLIS, MINN.; ROBERT GOLDENBERG, M.D., DIRECTOR, BUREAU OF MATERNAL AND CHILD HEALTH, STATE OF ALABAMA DEPARTMENT OF PUBLIC HEALTH, MONTGOMERY, ALA.; GEROLD L. SCHIEBLER, M.D., MILLER HEALTH CENTER, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF FLORIDA, GAINESVILLE, FLA.; PATRICIA T. SCHLOESSER, M.D., DIRECTOR, BUREAU OF MATERNAL AND CHILD HEALTH, KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT, TOPEKA, KANS.; VERNON SMITH, DIRECTOR, BUREAU OF MEDICAID INFORMATION AND POLICY DEVELOPMENT, LANSING, MICH.

Dr. FORCE. Mr. Chairman, members of the committee, the Association of State MCH and CCS Directors appreciates the opportunity

to appear before this committee and express our views on the administration's spending proposals for title V.

MCH programs have long demonstrated an emphasis on prevention, health promotion, and ambulatory care to reduce emergency room use and hospitalization.

CCS has focused on reduction of long-term disability through provision of specialized diagnostic treatment and case management services of high quality.

We believe the title V mandate to be the cornerstone upon which States and territories have been able to build the present safety net.

This network provides preventive and specialized health services for over 3 million of the most needy mothers, infants, and handicapped children.

Title V legislation provides a time-tested Federal-State-local partnership which has kept the needs of mothers and children paramount.

Mr. Chairman, we are particularly concerned about two aspects of the administration's present block grant design proposals.

First, without a continuing congressional mandate for mothers and children there can be no assurance that these populations will receive priority in States.

Second, elimination of Federal-State-local matching will remove the State incentive to continue their support in the future.

The combined loss of Federal and State matching funds could be upward of 50 percent. To combine spending cuts with a repeal of title V would place the patient population served by this entitlement in double jeopardy. The MCH and CCS delivery system could be devastated by an sizable displacement of the present State role.

Historically, women and children have had great difficulty in competing for health care dollars at all levels of government.

Examination of MCH and CCS funding trends over the years indicates that they continue to represent a disproportionately small share of health care resources compared to other groups. However, funds spent in this area have produced dramatic results made evident in lower infant and mortality rates, reduced incidence of mental retardation, and improved quality for millions of children.

Mr. Chairman, the association recommends that title V of the Social Security Act be retained. The Nation's economic future and security is very much dependent on the health status of its women of childbearing age and their offspring.

We would like to say something about another social security program and that is title XIX, and acknowledge the disastrous effect that capping medicaid would have on our Nation's children's hospital services. Highly specialized care could become unavailable to thousands of infants and children, many of whom are identified and referred for care through title V, MCH and CCS programs.

Finally, perhaps one of the most troubling aspects of the administration's block grant design is the elimination of existing maternal and child health care standards as a condition for Federal support.

These standards have been based upon national standards formulated by the medical profession as a whole. It is important that States provide services consistent with nationally recognized and

accepted professional medical judgment regarding the types of services which are essential and appropriate for mothers and children with various kinds of health problems.

Thank you.

Senator DURENBERGER. Thank you very much.

Dick Nelson.

Mr. NELSON. I am the director of the services for children with handicaps program, which is the designated crippled children's program in Minnesota.

Title V of the Social Security Act enabled each State to organize a crippled children's services agency for locating and providing diagnostic and treatment services to handicapped children. These agencies are the only—and I would emphasize only—specific public health agencies with the mandate to provide services to this group. They function with considerable flexibility. No two State programs are identical which we believe reflects the ability of programs to respond to the needs in their States.

In fiscal 1979, the program served approximately 1.2 million children and they expanded $86 million in Federal formula grants to $275 with matching State and local resources.

We believe that the programs have, and are demonstrating, capable leadership and a representative example of this is the scoliosis program in Minnesota.

In each of the past 5 years, 225,000 children in grades five through nine throughout Minnesota have been voluntarily examined in their schools for curvature of the spine. The leadership for this program, the training and the reporting is really accomplished by a half-time public health nurse in our program, and since its inception, we have been able to document a dramatic reduction in the number of children requiring surgery as a result of early treatment.

The health services block grant proposal will adversely affect the capability of States to serve the health needs of handicapped children. We believe that the abolition of title V would result in several major jeopardies. States would no longer have an obligation to maintain a CCS entity within their executive structures, which would compromise public health services to these children.

States would no longer be required to match Federal funds which in these days would, we believe, diminish resources available. The demand for public health dollars in States would undoubtedly reduce the level of block grant funds eventually intended to provide services now supported by title V.

In addition, the reduction or elimination of the Federal office of maternal and child health would result in the reduction in the Nation's capability to serve handicapped children.

There would be no Federal agency with the specific capability of providing technical assistance and consultation with regard to the health needs of handicapped children.

There would be no Federal mechanism for a designation of funds on emergent issues important to handicapped children.

The training of health care professionals crucial to provision of services to handicapped children now funded by title V at schools of public health and university affiliated facilities would be eliminated.

In addition, the Federal support of applied research would undoubtedly be curtailed.

We do believe that there is obviously a major need to control burgeoning Federal spending, but that this budgetary concern should not cast aside 70 years of thoughtful Federal involvement in health care for handicapped children.

Justice for these children cannot be served by budgetary expediency.

Thank you.

Senator DURENBERGER. Thank you very much, Dick.

Dr. Goldenberg.

Dr. GOLDENBERG. Mr. Chairman, I am an obstetrician that came to Alabama to work 5 years ago. Because prenatal care and appropriate hospitalization were less available to the poor then than they are now, pregnant women and newborn infants often died or were damaged in extraordinary numbers.

Many of these tragedies could have been prevented by assuring access to appropriate medical care. The kinds of tragedies I am talking about are cerebral palsy, mental retardation and things like that.

Five years ago, it was obvious to us in Alabama that only the State's title V agency had the power to do something about the problem we're talking about.

Since beginning work with that agency approximately 3 years ago, we have moved toward a statewide system of delivery care for the poor and their children.

We have provided prenatal care to virtually every woman in need. We have substantially reduced the number of women delivering at home. During this last 4-year period, we have reduced infant mortality at Alabama by nearly a third.

Potential savings from the reduction in the number of damaged children requiring institutional care can be calculated in the tens of millions of dollars for Alabama alone. Even these statistics don't take into account the 300 or 400 children that are born normal each year now that just 3 or 4 years ago would have been at least mild or mentally retarded.

These statistics also don't take into account the changes that these programs have made in the lives of low-income pregnant women who, in the past, often went from hospital to hospital trying to find a place to have their babies, or delivered at home because funding was not available to them.

These changes that I'm talking about did not occur by chance. They occurred because it was a single State agency, the title V agency, which was able to direct its own resources and other resources in the State toward solving a specific problem, the problem of infant mortality.

Without this targeting at the Federal level, funds desparately needed, and I believe intended by Congress to be used for women and children will be likely used to satisfy other stronger more vocal constituencies.

Specific examples will be found in the written testimony.

The proposed cap on medicaid will also decrease our ability to maintain our progress in reducing infant mortality. In fact, we

attribute a large portion of our success to the very vital relationship between medicaid and the title V program.

As you are well aware, even at its current funding level, medicaid is not universally available to all poor pregnant women.

The utilization or the acceptance of medicaid patients by many physicians is low. The system that has developed in Alabama allows the title V programs to provide preventive care, prenatal care, early infant care and lets medicaid pick up the more expensive hospitalized care for many indigent patients.

Each Federal program, the medicaid and the title V working together allows us to build a system of care that I believe that has been so successful.

Removing the medicaid entitlements will likely have a profound effect on the health care available to poor women and children in Alabama.

At the same time, to not insure that there will be a title V program will really do tremendous damage.

In summary, my recommendations include, No. 1, to preserve a separate legislative authority for women and children. To develop sensible programmatic requirements for State MCH programs. To consolidate the many programs directed at reducing infant mortality into one legislative program. To continue the medicaid entitlement and not implement the cap on the medicaid program and then to maintain a centralized Federal MCH authority.

Thank you. I'm sorry, I ran over my time.

Senator DURENBERGER. Thank you very much for your testimony. Dr. Schiebler.

Dr. SCHIEBLER. Mr. Chairman, Senator Bentsen, thank you very much for the privilege of appearing before you and the members of this committee. I am deeply honored by my esteemed friend and Senator, Lawton Chiles, graciously introducing me.

Senator Chiles had mentioned to you, Senator Durenberger, that I was involved in setting up in Florida what is now the highest administrative level of any maternal and child health office in any State government today.

My petition to you would be to consider, as you go through these hearings, an equivalent high administrative office within the Federal Government to administer maternal and child health and to develop appropriate linkages to other programs that impact on maternal and child health.

I believe that this kind of position in the Federal Government for maternal and child health will allow the integration of programs that you desire, whether they relate to special entities, or for the disease-a-week club, or for perinatal programs, or pediatric pulmonary programs, or whatever. The development of such integration requires that kind of elevated locus in the State or Federal Government. Included in such a perinatal/neonatal program in our State is that such a program has made a commitment from day 1 for a 4-year followup evaluation of what the program has done, asking ourselves continuously what are we doing and how well are we doing it?

That longitudinal assessment of these children is done by individuals besides those who took care of the child in the neonatal intensive care unit.

As you look at all the various programs, whether they are SSI, or DD, WIC, title V, title XIX, EPSDT, or programs relating to Public Law 94-142 in order to fully coordinate those programs, you need this kind of a lead agency, because you are dealing with parallel power structures in HHS, in Education, and even in Agriculture.

In my county in Florida, there are 31 different ways a child can get screened medically, often screened multiple times without finding a home for treatment. The creation of such a lead agency would address such overlap and duplication

Well, what has been the cost-effectiveness of the leadership of this kind of agency? First, fetal mortality for the first time in Florida is at or below the national levels; second, there has been a decrease in maternal morbidity; third, in the 4-year longitudinal assessment of children admitted to our statewide neonatal care centers, 92 percent of those children have been assessed as having superior or normal intelligence indicating a significant decrease in mental retardation in various weight groups.

We have a statewide telephone system that allows any physician anywhere in the State to get an infant in need into one of the centers throughout the State.

Our scoliosis screening program in our public school system, the children's kidney program, and the children's cardiac problems—are all national models. We have found over 500 children in the first year of the scoliosis screening program with significant curvatures of the spine that had not been previously detected.

Thyroid function screening as a component of our statewide neonatal biochemical screening program has detected early, 30 children in the first year with abnormally low thyroid function—again preventing significant mental retardation.

The children's regional diabetes program, has resulted in a 90-percent decrease in inpatient hospitalization days for children with diabetes.

Besides that, this kind of lead agency attracts other sources of funding. Federal funds are the magnet, and indeed the seed for other funding sources. The Federal funds for neonatal intensive care are very small. We have attracted, from a variety of sources, almost $50 million for our neonatal intensive care program.

We have attracted from the Robert Wood Johnson Foundation a grant of $600,000 matched 3:1 with medicaid funds to bring increased health care for children living in rural areas.

A lead agency also provides the leadership for a variety of promaternal and child health legislation, such laws amplifying maternal and child health programs.

So, in summary, I advocate a lead agency for maternal and child health with an increased status in the Federal Government because first, it improves the integration of programs; second, provides that programs under its aegis have periodic evaluation; third, it acts as a basis for attracting other sources of funds; and fourth, it is a fulcrum for improved maternal and child health legislation.

Thank you, sir.

Senator DURENBERGER. Thank you very much.

Pat, I have an announcement for you, and that is that you are not going to go next and that is because your Senator, who is also

chairman of the committee, doesn't want you to go on until he gets here, and he's on his way.

Dr. SCHLOESSER. Thank you.

Senator DURENBERGER. Especially now that the former chairman of the committee is here. So, we are going to go to Vernon Smith next and Vernon, I introduced earlier, I guess.

Mr. SMITH. Thank you, Mr. Chairman, I am Vern Smith, policy director for the Michigan medicaid agency within the Michigan Department of Social Services.

I have also served as budget director for the department. I currently serve as chairman of the national technical advisory group for EPSDT.

I am pleased to appear before the committee today to summarize the key points of my written testimony.

First, Michigan and other States have shown that title XIX, title V cooperation within the current structure and without a block grant can work effectively.

As one indicator, the medicaid program, which is fiscal intermediary for both titles V and XIX in Michigan, last year processed $10 million of crippled children's claims and an additional $8 million in title XIX claims for title V children who were also eligible for title XIX.

Second, the EPSDT program achieves its purpose by providing a focus and emphasis on preventive health care within the medicaid program itself.

This is illustrated by the fact that last year of the total Michigan medicaid expenditures of just over $1 billion, $8 million was spent for EPSDT screenings, but $232 million was spent on diagnosis and treatment for EPSDT eligible children.

Clearly, EPSDT is integrated into and an intrinsic part of medicaid and no proposal should be considered to separate either the administrative or the financing responsibility for EPSDT from the medicaid program.

Third, the results of a medicaid cap will be reductions in both preventive and ongoing care. I can say that with confidence because it is already happening in Michigan.

In Michigan, the lack of State matching funds has served as a powerful incentive to cut medicaid. We have moved well beyond sensible cost containment into arbitrary cost-reduction actions to constrain the program within State resource limits.

As Mr. Paul Allen testified yesterday, Michigan's actions are saving $238 million this year. The point must be made that these savings are shared equally with the Federal Government due to Michigan's 50-percent Federal matching rate even though it has been entirely at the State's initiative, and the State's effort through which the savings are achieved.

Fourth, we have found it impossible to cut the program without hurting recipients notwithstanding our best efforts to minimize the harm.

For example, in the current fiscal year, 1981, we have cut the number of funded EPSDT screenings by 8 percent, at the same time the number of EPSDT eligibles has increased by 12 percent.

We have reduced provider's fees, which were already too low, by 10 percent, and we have reduced the scope of coverage, for example, for certain drugs.

Fifth, program cuts often are shortsighted, and result in increased costs in other areas. This occurs as childhood conditions are left undetected and untreated and as higher cost care is used because mainstream primary preventive care is restricted.

The recommendations which flow from this testimony may be summarized succinctly. One, do not cap medicaid because it will disproportionately hurt medicaid children, and second, provide States the authority and the flexibility to manage the medicaid program, including its EPSDT component in a prudent, effective, and efficient manner.

I thank you.

Senator DURENBERGER. Thank you very much.

Pat, do you think you could go without Bob. I suppose he wants to hear you. You haven't given him your 5-minute lecture yet, so maybe if you don't mind my asking some questions of other people and then when Bob gets here, you can make your presentation at that time.

Is there anybody out here on this panel that thinks that putting a cap on medicaid, as proposed by the administration, is a good idea?

[Dr. Goldenberg nodding head negatively.]

[Laughter.]

Senator DURENBERGER. Is there anybody in the group that likes the proposal on the health services block grant as you have read about it and heard about it so far? Anybody favor it?

[No response.]

Senator DURENBERGER. Indications are "no" to both of those questions.

My third question would be, is there anyone here that thinks that we ought to get rid of title V or, I think, somebody referred to certain sections of XV and there are certain sections of XIX, my question being: Should we take some 40 or 50 years of history of providing maternal and child care through the Social Security Act out of the Social Security Act and put it into some form of block aid to the State?

Dr. NELSON. If I could speak to that. I think there is a feeling that title V of the Social Security Act is not a peripheral to the Social Security Act. It addressed the needs of very vulnerable groups of our population, a core group of our population.

While title V is not chiseled on stone and it hasn't come down from the mountain, there must be that kind of mandate for serving this vulnerable population of mothers and children. The feeling is not that title V is sacred, as written, but a title V written in some fashion is extremely critical to providing important services.

Senator DURENBERGER. Could we start with you, Dick, and then have other comments on possibly bringing in related maternal and child sections from other parts of the Social Security Act into title V and then perhaps also bringing in—we have heard about SIDS earlier, and we heard about what the Department of Agriculture is doing—bringing in other related programs from other program grant areas into a revised title V.

Would you start, react to that, and then maybe others could?

Dr. NELSON. I'll maybe address that from the handicapped child side and then someone else from the maternal and child health side.

I think on a State level, that this is really occurring in many States. In our State, for example, the funds for the genetics program, hemophilia, the supplemental security income, the disabled children's program are all integrated at the State level with the work of the basic CC agency, and so that if the Federal funding for those programs were to be brought together in a consolidated fashion, I think most States would deal with that very easily. In fact, they would support that because it would enable them to coordinate their efforts.

Dr. GOLDENBERG. I would agree with that, Senator.

The SIDS program, hemophilia, genetic diseases are generally handled now through the maternal and child health agency, and the fragmentation that comes down to us from the different Federal entitlements of these different programs is a hindrance to us providing the services.

Folding those into a single maternal and child health block grant or title V program would be a tremendous help to us at the State level.

Senator DURENBERGER. Dr. Schloesser.

Dr. SCHLOESSER. We were surprised that programs such as family planning, which States had been administering under title V auspices, were not folded into the title V legislation originally. A more recent example was adolescent pregnancy, a concern of maternal and child health for many years.

Senator DURENBERGER. Anyone else want to comment on that?

[No response.]

Senator DURENBERGER. My time has run out.

Senator Bentsen, you are next under the Senator Long Early Bird Rule.

Senator BENTSEN. Thank you very much, Mr. Chairman. I am really here to listen because I have a very deep concern about care for mothers and children and I feel like it is such a major investment in the kind of productive life they are going to lead. My concern, too, that if we get into one block grant in spite of my concern for the elderly and their health care, political forces will be such that you will see child health care and the care of the mother really get the short end of the allocation of funds.

So, I was here really to get some additional arguments.

Senator DURENBERGER. Senator Long.

Senator LONG. Thank you, Mr. Chairman.

Let me ask a question here. Are there any witnesses who agree with President Reagan's approach to the effect that States ought to be permitted to have a great deal more latitutde in deciding how they want to use their money, with less direction out of Washington for freedom of individual initiative and individual discretion at the State and local level? How do you feel about that?

Mr. SMITH. Mr. Chairman, if I might speak to that issue. From a medicaid perspective, medicaid agencies have felt constrained in many ways by the current Federal statute and regulations which

constrain actions a State can take which a State would believe would enable it to act in a prudent cost-efficient manner.

States are motivated, I believe, more by the participation of State funds than by the availability of matching funds from the Federal Government in their administration of the program.

The States have to face their own State legislatures and the appropriations of those State funds which are matched.

Accordingly, therefore, it is one of the frustrations of a State when a State has to cut back on a medicaid program. That for every $2—in order to save $1 of State funds, it must cut the program for beneficiaries in terms of reimbursement to providers by $2 in order to save $1 of State funds. So, I think that States are most interested in increased flexibility, which would allow them to act in the public interest to administer the program in a prudent and efficient manner.

Senator LONG. There are some people in the administration who take the view that they are not going to find much sympathy for what they are trying to do in welfare with the State administrators because the State administrators have tended to like having a large bureaucracy at both Federal and State level; they would like to just stay with the status quo of big bureaucracy up here matched by big bureaucracy at the State level under the existing establishment.

I don't know whether that is right or not.

My impression has been that at the State level, most effective administrators have been people who would look at their overall problem and assign the money they had based on what they thought reasonable priorities would be. But some of the very best of them have taken the view that their agency has just so much money and by the time the year is out, the program people had better turn 5 percent of it back in or they were going to get somebody else to run the program on the theory that any good administrator ought to be able to keep track of what he has to work with and find ways where he could be more effective in some areas and where he could reduce expenses and personnel in other areas and come back in here showing some economies by just doing a better job.

If I understand what is being testified here, you people are taking the view that no, it can't be done.

Dr. NELSON. If I might speak.

From a title V perspective, I think most State agencies feel under current legislation they have a good deal of flexibility and if anything, the formula grants, reflect much of the intent of the Federal block grant proposals. However, without the mandate for mothers and children to have identified programs and agencies to carrry out the work, the competition for nondesignated funds will be very, very severe for the maternal and child health agencies.

Senator LONG. The one thing that I don't think ought to be cut is the funds for family planning. I happen to think that all you are doing by cutting back there is just creating yourself a great big welfare burden that need not be. A lot of young people don't know anything about family planning—they think they know about 10 times as much as they really do know—and if they were better educated about what life is all about, we just wouldn't have them

presenting us with large numbers of children that they have no way to support. I think putting up Federal funds for family planning was a very wise decision on the part of Congress.

My guess is that for every dollar we spend on family planning, if it is spent effectively, it will save $10.

Do you people tend to agree with that?

Dr. GOLDENBERG. Absolutely.

Senator LONG. I see most of you nodding your heads.

Now, there is an area where I think that we ought to be more effective and maybe even spend more of our funds. I don't see why we can't do it be finding the money through savings in some other area.

Frankly, if I had the hospital program that was operated in Louisiana—not that I would like to do it—I know I could save a lot of money in Louisiana by just saying that there are some people who have been regarding themselves as eligible who would not be eligible.

We have historically made those State hospitals available to all kinds of people who can pay something, and I think that we could save something by changing that if we had to do it.

Senator DURENBERGER. Well, thank you.

The CHAIRMAN. Mr. Chairman, I would like to call on Pat Schloesser, she has been waiting for me to introduce her, and I have been working on farm programs, maybe we have to shift price supports to your program. So, if I get mixed up, you can give us what you think the price of wheat ought to be. [Laughter.]

Senator BRADLEY. Mr. Chairman, could I inquire——

The CHAIRMAN. Yes.

Senator BRADLEY [continuing]. How long will the hearing continue would you estimate?

The CHAIRMAN. You mean, the full hearing?

Senator BRADLEY. Yes.

The CHAIRMAN. We have one other panel, I would say 45 minutes.

Senator BRADLEY. Thank you very much.

The CHAIRMAN. Pat, I guess you didn't have a chance to make a statement. If you want to do that, and then we will get back to questions.

Dr. SCHLOESSER. Senator Dole, Senators other and friends of children, I am Dr. Pat Schloesser, Director of the Bureau of Maternal and Child Health in Kansas. I have been associated with the title V program since 1952, my full professional career.

A main charge of title V has been to look into causes of infant mortality and apply measures to eliminate these.

When I look back to 1952, there were 1,200 babies who died that year in Kansas, and perhaps another 1,200 babies were damaged by improper care during pregnancy or bad timing of pregnancy.

Today, I would like to report that 400 babies died in Kansas last year. A lot of those deaths still could have been avoided, but we have come a long way in these 28 years.

So, naturally, we are mighty proud of the Kansas program. I think if you have known Kansans, we Kansans do like to talk, not only about our wheat, but about our people, our accomplishments

in child health, in family health and giving Kansas families a healthy start.

In a farm State like Kansas with a small population and a large geographic area, from the very beginning of our economy, children were important.

When my grandfather homesteaded to Kansas back in 1870, the health of his 12 children was of primary concern. The same holds true for Kansans today.

I think you know that Kansas is fiscally conservative as a State, but progressive when it comes to people programs. Most maternal and child programs developed before Federal legislation. A 1915 law set up a unit in State government to look into the causes of death and disease and apply measures to prevent these in both mothers and children.

In 1931, a State law created the crippled children's program. In 1965, a law provided for family planning clinics statewide, the first of its kind in the Nation.

Today, using the title V as a matrix, we have "umbrellaed" allied health programs into one central operation. I would like to name these off: Maternal and child health, crippled children's program, SSI, WIC family planning, genetic disease, adolescent pregnancy, school health, new born visiting, migrant health, and licensing of child care away from home. By consolidating programs, we have kept our staff "lean", and moved most of the Federal money out to communities.

There is a need to work closely with the private sector in Kansas as we don't have clinics staffed with full-time public health physicians. So, the private physician is a team member in all of our programs.

One program I am particularly pleased with from a cost-effective standpoint is in the area of adolescent pregnancy, a maternity and infant program limited to the highest risk population. Such programs exist in nine Kansas counties and last year the Kansas Legislature appropriated some State dollars for the first time to assist the title V dollars.

Lastly, I would like to say that title V has been our friend. It has been an assurance of basic support for child health—when political forces in our State, such as a strong mental health lobby—incidentally, my husband is a pyschiatrist—can influence State funding priorities. Another year, the aged might have priority. Title V legislation has assured that basic prevention dollars and treatment dollars for mothers and children including the handicapped would flow on a predictable basis so that programs could be planned over 10 to 20 years.

The CHAIRMAN. You indicated about a minute ago that you have been able to coordinate a lot of programs in Kansas. Has that had a direct impact on delivery of health services to mothers and children?

Dr. SCHLOESSER. I would like to give you one example. With EPSDT, back in 1972 or 1973 when our State initiated this program, the title XIX authority turned to the title V office and said could you help us in working out a delivery system to carry out this screening of all these children, and we said, yes, we think we can help you on this.

We initiated a training program of public health nurses statewide and were able to certify some 400 public health nurses in communities who could carry out the initial screening, followup and referral to the private sector for treatment. This, then, led to another spinoff.

We find today that the community health departments are screening three to four times as many non-title XIX persons as those who are receiving that benefit. So, working cooperatively between XIX and V, we've generated more health services to all Kansans.

The CHAIRMAN. Thank you, Dr. Schloesser.

Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

For those of you who are fearful of the administration's approach of block grant for maternal and child health care, and I think when something new comes along, there is some legitimacy to that, but most of the opposition has come from those, including, I think, the feeling you reflect here today, that the State program will be lost in the shuffle at the State level.

My question is: considering the fact that the States already have had considerable experience in running programs like what you administer regardless of where the funding comes from, it is still State administered, what makes you think that the States will not maintain their efforts in this direction?

Any of you want to respond.

Dr. FORCE. Senator Grassley, I think that one of the problems that we are very concerned about right now, of course, are major shortfalls in other programs. Major shortfalls are expected in other Federal and State funded programs such as the medicaid program, and in some States, programs for the aged. We feel that the lobbying efforts for maternal and child health programs would be much more difficult if we did not continue to have some sort of national mandate to provide some basic services for mothers and children.

I think we really feel very strongly that there needs to be a Federal role—a Federal presence to provide some structure through which the States can meet——

Senator GRASSLEY. It is almost like saying——

Dr. FORCE [continuing]. Their basic mandate to mothers and children.

Senator GRASSLEY [continuing]. Now, that is almost like saying—if you would let me interfere and interrupt at this point—that somehow we have a corner on all the concern here in Washington, D.C. that State legislatures would not have that equal concern. Do you have more confidence in those of us in the Congress than you do in your own State legislatures—legislators?

Dr. FORCE. I think so. I will have to answer that affirmatively.

Senator GRASSLEY. You think you do?

Dr. FORCE. Yes.

Dr. SCHLOESSER. I would like to respond from the standpoint of prevention and treatment. When you put even one a treatment dollar on a child, a handicapped child, you get more of a return, more preventive effort. I don't think nationally or in the States that we have been committed the last 15 years to putting dollars on prevention. Most of the health dollars have gone to treatment,

primarily adults and even in our State, Kansas has been much more willing to put health dollars on the treatment of the handicapped than on the broad area of promoting prenatal care and primary prevention efforts. So, treatment versus prevention will be of concern.

Senator GRASSLEY. If maternal and child health care programs could be separated into their own block grant, and that has been suggested. In fact, there was just this week a person in from State to visit with me privately about the same issues that you are discussing in this panel.

Would opponents of the administration proposal be willing to take a 25-percent reduction in the dollar amount for maternal and child health care programs?

I guess the obvious answer to that is that you would rather not, but if you had your own block grant, the direction from Washington, D.C., would you be willing then to accept a 25-percent reduction and maintain your own identity.

Dr. NELSON. It may sound like heresy to some people in the room, but I think the issue is more than dollars. The issue is structure, the mandate. And the Federal mandate, it's viewed by most of us as indispensable to overall direction of care for mothers and children. Obviously, we feel that the 25-percent reduction would translate into reduced services because in the maternal and child health area, we are lean on many of the administrative costs that some of the Federal agencies have. But that, I believe, is a secondary issue.

The primary issue is maintaining a strong Federal presence to help direct the States and assist States in serving its population of children.

Dr. SCHIEBLER. Senator Grassley, I would say that the cardinal tenet here is, as you discuss funding, that you can discuss a creation of an organization for maternal and child health at a high enough level in the Federal Government that preserves the best aspects of title V and its fundamental commitment to mothers and kids.

Unless you give it that status where it can fend for itself, we can acquire and coordinate problems, I think all funding mechanisms may fail mothers and kids.

Senator GRASSLEY. I sense a fair unanimity, as I have seen heads shake, on this particular question.

Is there anybody that takes exception to it? To the points that have already been expressed?

Dr. SCHLOESSER. I would just like to reemphasize prevention. If we cut back the prevention dollar, we are going to spend more money on the treatment side.

Senator GRASSLEY. I can appreciate that. I realize that that is a legitimate point of view.

The CHAIRMAN. Senator Heinz.

Senator HEINZ. Just one followup to another question. To followup on what Senator Grassley is saying, where are you afraid the money will go to if you lump them in block grants?

Dr. FORCE. We think the money will probably go to those groups which have really the strongest advocacy in the State. Quite frank-

ly, poor mothers and children do not represent a large advocacy group.

Senator HEINZ. And specifically which groups?

Dr. FORCE. Well, I think this will vary from State to State, Senator Heinz.

Senator HEINZ. Well, in your State.

Dr. FORCE. In our State it would be probably the medicaid program which this year is facing something like an $85 million shortfall.

We also right now have serveral class action suits going on in the State relating to the institutionalization of the mentally retarded and mentally ill. Litigation is costing the States millions in terms of providing alternative living arrangements for these individuals.

These are all very justified causes. I don't mean to imply at all that these aren't justified reasons to fund these services, but I am just trying to point out that these groups do have, we believe, much stronger advocacy for their programs than do poor mothers and children.

Senator HEINZ. Very well.

Let me ask Mr. Vernon Smith a question.

Mr. Smith, I have been informed of some statistics that are kind of alarming as to EPSDT programs, which are that approximately 60 cents of every EPSDT dollar goes to paperwork, administrative-type activities, and the remaining 40 cents of every dollar is spent on services. Furthermore, I am told that only 20 percent of children eligible under the program are being reached and that 50 percent of those screened and found to need, did not get appropriate followup services.

My question is: In this process of consolidation that occurs under a block grant scheme, would you believe that the 60-cent paperwork figure could be redirected to improving access to followup? And if you do believe that is theoretically possible, can you provide any specific suggestion as to how to insure that this would in fact result?

Mr. SMITH. Well, Senator, I will try my best to answer that very complicated question. I am not specifically familiar with statistics, which you have cited, but, in general, they seem to ring true with the experience in the States. The EPSDT program by its very nature involves a lot of outreach, seeking people, encouraging people, directing people into preventive care.

The outreach is an expensive aspect of the program, but it is an essential part of the program in terms of directing people into the EPSDT system so that they can become screened and then from there diagnosis and treatment can follow.

The EPSDT program right now is somewhat burdened by documentation requirements and other regulatory requirements in terms of a specific process and methods by which outreach has to be done and time frames within which treatment has to be initiated, documentation of that fact, documentation of social services which might be offered, such as transportation in order to insure that children are able to reach the screening site and that they can achieve the necessary treatment.

We are working on those cooperatively at this time with people within the health care financing administration.

I believe we have a commitment to amend the regulations to insure that the program can operate more efficiently. I believe this is one of the singular issues with State medicaid agencies in terms of streamlining regulations or streamlining a program. I think EPSDT is clearly a program that State medicaid people believe in, but at the current time there is an effort underway to give States some of this necessary relief so that they can administer the program more efficiently.

I don't think there is any question that the program is efficient in terms of doing what it is doing within the medicaid structure, but as I suggested in Michigan, we spend $8 million for screenings, $232 million for diagnosis and treatment. The primary role of EPSDT within the medicaid structure is to provide focus and emphasis on preventive health care for children.

In that regard, it is achieving its goal. And the figures that you cited in terms of the proportion of money spent for documentation, and paperwork, and so on, I think our proportion is a very small amount, the $8 million, in relation to the larger amount which is really the important part of the program, which is insuring that the kids receive the care they need.

Senator HEINZ. Well, just so the record is clear. The information, you may not have what I have, 60 cents out of every dollar is spent on paperwork. Only 40 cents is spent on services.

Mr. SMITH. Well, I would not accept those numbers in the sense that the EPSDT program is sometimes construed as a screening program, and I believe the numbers that you have probably relate to the screening aspect and not to the whole EPSDT, early and periodic screening diagnosis and treatment. The whole program is much broader than that and I don't think there is any conceivable way that we could conclude that 60 percent of all of the dollars spent on EPSDT eligible kids goes for paperwork.

I will grant you the point that there is at this point in time, from a State perspective, an unnecessary level of paperwork and documentation associated with the program with the goal—it's a laudatory goal—of providing a tracking mechanism so that we know when children have been screened, and at the necessary periodicity point they are recontacted so that every year or two, depending on their age, they are called back in. This requires something of an elaborate tracking mechanism, and because of that there are some documentation and tracking requirements which take part of the resources of the program.

Senator HEINZ. Mr. Chairman, let me say for the record that the statistics that I have cited came from the Commonwealth of Pennsylvania medicaid program. They told my staff that represents everything from the "E" to the "T," E-P-S-D-T.

Mr. SMITH. Yes.

Senator HEINZ. Other people have been saying that for the record.

Thank you.

Mr. SMITH. I'd appreciate reviewing the statistics, Senator, and my sense of things is that those certainly don't apply in Michigan, nor nationally.

[The information was subsequently furnished:]

STATEMENT TO SUPPLEMENT THE TESTIMONY OF VERNON K. SMITH, PH. D., BEFORE THE COMMITTEE ON FINANCE, U.S. SENATE

This statement is to provide a more complete response to the question addressed to me by Senator Heinz regarding the cost of paperwork in the EPSDT program, and how the costs of paperwork could be redirected to improve access to follow-up care.

The question was framed to suggest that costs attributed solely and directly to EPSDT "paperwork" are as much as 60 percent of total program costs, and that only 40 percent of program costs are allocated for services such as outreach, informing, case management, screening, diagnosis and treatment. The implication was that such paperwork was unnecessary and counter-productive, and that the proportion was excessive.

Further research into the issue indicates that the referenced 60-percent figure includes within the definition of "paperwork" the following elements of EPSDT program and service delivery system in Pennsylvania:

Outreach and informing.—The costs of caseworker time for outreach and explanation of the program to eligible persons; plus the costs of an administrative fee paid to a contractor for the recruiting and training of providers; processing of screening results, quality control and other similar overhead activities.

Transportation.—The costs of providing transportation to the screening appointment and any subsequent appointments for treatment.

Scheduling.—The costs of caseworker time to schedule screening, dental and medical treatment appointments.

Data processing and documentation.—The costs of tracking, matching follow-up appointments with screenings, preparing reports and documenting when and which services were provided.

It is found, therefore, that the term "paperwork" in this context is broadly defined to include any non-medical costs of EPSDT.

Based on data provided to me by the Commonwealth of Pennsylvania EPSDT program, it is found that such non-medical costs are 60 percent of the screening component only. When compared to the full EPSDT program (including treatment directly related to EPSDT screenings), it is found that such non-medical costs are about 49 percent.

Although these percentages may sound excessively high, it should not be concluded that all non-medical components of EPSDT are unnecessary or counter-productive. Indeed, the service elements of the program (such as outreach, informing, follow-up, transportation, tracking, etc.) are essential to the case management aspect of a preventive health program such as EPSDT and cannot be dismissed categorically as unnecessary or counter-productive.

Further, EPSDT administrative overhead is relatively expensive because it is heavily labor intensive, reflecting a person-to-person, face-to-face method of service delivery. However, administrative and other overhead costs, including the costs of paperwork, are generally found to comprise a substantially lower percentage in other states than those cited above.

For the Michigan EPSDT program, for example, direct administrative costs are less than one percent of total costs of screening, diagnosis and treatment for EPSDT eligibles. Total costs for administration, outreach, informing and all screenings, total about 5 percent.

Over the first 10 days in April 1981, other states were polled by telephone to obtain an indication of EPSDT administrative costs. The following question was posed: "What proportion of EPSDT program costs are represented by the general administration of EPSDT, including all costs associated with outreach and case management." All states could not produce this statistic immediately, but the following data are believed representative:

State responses: Proportion of total EPSDT program costs allocated to administration, including outreach and case management

State	
California	46
Florida	29
Idaho	19
Maine	8
Maryland	30
Michigan	5
North Virginia	25
New Jersey	5
Ohio	8–9
Wyoming	3

The data obtained by phone do not represent a scientific sampling and undoubtedly represent different definitions from state to state. The data nevertheless suggest that the proportion of program costs allocated to administration depends on the volume of services and on the approach used in each state in implementing the program.

Senator Heinz' point remains well-taken that certain elements of EPSDT *are* paperwork intensive and the certain elements of the federally imposed paperwork requirements are unnecessary and even counter-productive. Specific reference is made to: Mandatory procedures and processes for outreach and informing; excessive and inflexible documentation and tracking requirements; and mandatory and universal dental referrals.

The recommendation is reinforced to repeal Section 403(g) of the Social Security Act, which provides the statutory basis for the above paperwork intensive requirements of the EPSDT component of Medicaid.

The repeal of Section 403(g) and associated regulations would substantially reduce the proportion of EPSDT resources allocated to "paperwork," and would allow the redirection of these resources to improving access to needed follow-up medical care.

The CHAIRMAN. Well, I want to thank the panel very much. We appreciate your coming.

We are going to try to work out some of the problems you have raised. I am not certain whether we can accommodate every question, but we have some flexibility. We are not locked into any one idea.

Thank you very much.

[The statements of the preceding panel follow:]

TESTIMONY OF THE CHILDREN'S DEFENSE FUND BEFORE THE FINANCE COMMITTEE OF THE U.S. SENATE REGARDING THE IMPACT OF THE REAGAN ADMINISTRATION'S BUDGET REDUCTION PROPOSALS ON HEALTH CARE FOR MOTHERS AND CHILDREN

Based on research and extensive consultation with child advocates, the Children's Defense Fund presents its analysis of the impact of the Reagan Administration's budget proposals on health care for mothers and children. The testimony discusses the adverse impact of the budget reduction and consolidation proposals and sets forth possible avenues of reform which would promote both program costsavings and better maternal and child health care.

I. INTRODUCTION

Mr. Chairman and distinguished members of the committee: The Children's Defense Fund (CDF) is pleased to have this opportunity to submit testimony to your Committee today on the implications for mothers and children of the Reagan Administration's proposed health budget reductions and program consolidations.

CDF is a national public charity created to provide systematic and thoughtful advocacy on a number of issues that affect children and families. Over the years, CDF has produced lengthy reports on major health, social services, and education programs affecting children. In each instance, we have not only reported on the successes or failures of each program, but have also sought to develop a careful and responsible agenda for reform that would help redirect public funds in a more effective fashion.

In the area of health, we have extensively investigated the performance of the major health programs for mothers and children, including Medicaid, EPSDT, and the Title V Maternal and Child Health and Crippled Children's Program. On the basis of expertise gained through our research, we have worked closely over the years with Congress and Department of Health and Human Services staff members to remedy progam inequities and improve program performance and accountability.

We come before you today, not to demand the unobtainable, but to share with you our knowledge about health programs for mothers and children. While we have deep concerns about the route for maternal and child health which this Administration proposes to chart, we also come prepared with an agenda that will both achieve program cost savings and build on this Committee's already considerable commitment to the cause of maternal and child health.

II. THE ACHIEVEMENTS OF THIS COMMITTEE'S HEALTH PROGRAMS FOR MOTHERS AND CHILDREN

The Medicaid and Title V Maternal and Child Health and Crippled Children's Programs represent this Committee's longstanding concern about the availability of accessible, high quality maternal and child health services for disadvantaged women and children.

The Title V programs, enacted 46 years ago as part of the great wave of New Deal social reform measures, provide state health departments with federal funds to improve the health of mothers and children. In 1965, Congress enacted the Medicaid program, and in 1967, added Early and Periodic Screening, Diagnosis and Treatment services for Medicaid-eligible children. These programs, in combination, have helped make dramatic improvements in the health status of low-income mothers and children.

A. The impact of medicaid.

The major health insurance program for the poor, Medicaid has entitled millions of impoverished families to the most basic health care services, including physician and hospital care for pregnant women, and a broad array of health care for their children. In fiscal year 1976, more than 23 million persons, 45 percent of them children, received benefits under the program.[1]

While Medicaid has existed only since 1965, its roots are found in the original Social Security Act, which first established a public assistance program for those who could not work. While the original Act did not provide direct aid for medical expenses, the cost of medical care was included in determining the amount of necessary support.

The Social Sucurity Amendments of 1950 and 1960 greatly expanded federal involvement in medical assistance. By the time Medicaid was enacted in 1965, all States participated in the Kerr Mills program, the predecessor of the present assistance program for the poor.

Today, Medicaid reaches an extremely impoverished population—elderly, blind and disabled persons, and mothers with dependent children, who do not have the support of a spouse. To qualify for assistance, these families must, by definition, be among the nation's most truly needy.

A sampling of the allowable income levels for Medicaid-eligible families aptly underscores their need.[2]

Maximum allowable[1] annual income for a family of 4 in 1980

State	Income
Colorado	$3,924
Delaware	3,444
Hawaii	6,552
Idaho	4,392
Iowa	5,028
Kansas	4,200
Louisiana	2,244
Maine	3,984
Minnesota	5,448
Missouri	3,240
Montana	3,972
New Jersey	4,632
New York	5,172
Oklahoma	4,188
Oregon	5,472
Pennsylvania	4,476
Rhode Island	4,668
Texas	1,680
Virginia	3,156
Wyoming	4,080

[1] The official CSA poverty income guidelines for a non-farm family of 4 in all states, except Alaska and Hawaii, is $8,450 per year. The guidelines for Hawaii allow $9,720 per year.

[1] Health Care Financing Administration, Data on the Medicaid Program (1979 Ed.).

[2] These financial eligibility levels essentially apply to medically needy families, as well. In some states, medically needy families are permitted to retain a few additional dollars to meet subsistence needs.

Medicaid's achievements have been substantial:

Medicaid has markedly expanded minority families' access to essential health services.[3]

Medicaid, in combination with Medicare, is the primary cause for the declining importance of income as a determinant of health care utilization in this country.[4] Medicaid has helped close the health care gap between the poor and non-poor.

Since 1967, there has been a slow but steady decline in the incidence of low birth weight among disadvantaged and minority children in the United States.[5] Low birth weight has been determined to the be a major factor in the incidence of infant mortality. Moreover, it has been estimated that for every 3 infants who now survive at birth, another 2, who might have been born so severely handicapped as to require a lifetime of institutionalization, will have a chance to grow and thrive.[6]

Since the inception of Medicaid, 25 percent more minority, low-income women have begun prenatal care during the first trimester of pregnancy.[7] There is little doubt that their ability to purchase these essential services has had a notable impact on their access to care.

Medicaid has permitted states to markedly expand their public health activities in rural communities and inner cities, where health manpower shortages are at their greatest. Indeed, Medicaid is a major financing mechanism for public hospitals and clinics.

Despite Medicaid's achievements, however, there are still millions of poor women and children who fail to receive essential health care. The Department of Health and Human Services estimates that Medicaid recipients comprise only about 59% of the poverty population, with beneficiaries constituting less than 20% of the poverty population in eight states (Alabama, Arkansas, Mississippi, South Carolina, South Dakota, Tennessee, Texas and Wyoming).[8] Because many states maintain low public assistance standards and choose not to provide Medicaid to all needy families,[9] million of the nation's poorest persons have no health insurance coverage.

B. The special mission of EPSDT

In 1967, after investigating the health status of the nation's poor children, Congress enacted a special series of child health benefits known as the Early and Periodic Screening, Diagnosis and Treatment Program. Realizing that good health care for children necessitated a special type of commitment beyond simply paying medical bills, Congress mandated state medicaid and Title V agencies to actively inform children of the importance of health care and to provide them with screening, diagnostic and treatment services.

Since its inception, EPSDT has slowly but steadily grown into a comprehensive health program targeted to reach millions of children. Through EPSDT, children can receive benefits not available to them through any other health programs, including comprehensive health assessments, vision, hearing, and dental care, and the support assistance needed to actually receive services. Today, EPSDT services are available from a wide range of health providers, including physicians, community health centers, schools, Title V-funded clinics, and Head Start programs.

Studies of the effectiveness of the EPSDT program have shown its success:

In North Dakota, children participating in EPSDT were found to have 40 percent less expensive hospital bills than those who were not enrolled in the program.[10]

Physicians at the University of Maryland in Baltimore reported that after screening 361 children, 335 had referrable conditions. In their view, "not one of these conditions would otherwise have been recognized so early in its course" without the program.

In 1978, more than two million children received EPSDT screenings with at least one previously undetected condition discovered in 48% of all cases.[11]

The EPSDT Demonstration Projects found that fewer than 17 percent of the almost 7,500 children screened had had a previous examination comparable to what is called for by the program. Sixty to eighty-five percent of the health problems

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[3] APHA, Minority Health Chart Book, 1977 (pp. 80–81)

[4] PHS, Health, United States, 1979 (p. 132)

[5] Ibid, p. 112.

[6] Goldenberg, Robert, M.D. "Handicapping Conditions in Alabama" [Draft, 1980], p. 3.

[7] Health, United States, p. 112.

[8] Health Care Financing Administration, Data on the Medicaid Program, 1979 Edition (p. 62).

[9] For example, 19 states fail to cover low-income women pregnant with their first child, and only 20 states cover all financially needy children under 21. Moreover, only 33 states have chosen to provide coverage to medically needy families who do not qualify for public assistance but have inadequate income and resources to pay for essential health services. See, Data on the Medicaid Program, op. cit., at p. 27.

[10] Applied Mgmt. Sciences, "Assessment of EPSDT Practices and Costs—Report on the Cost Impact of the EPSDT Program", pp. 23, 28.

[11] Data on the Medicaid Program, op. cit., at pp. 55–56.

found in these children were previously unknown and untreated, even though 80 percent were chronic.

Although EPSDT still reaches only about one-fourth of all eligible children, the program has substantially improved in size and quality since its inception. Moreover, the program has had "ripple effect" on other health programs for mothers and children. In some states, for example, the nutritional assessment component of the EPSDT health screen has allowed local health clinicians to more quickly and effectively link nutritionally deficient infants to the benefits of the Supplemental Food Program for Women, Infant and Children (WIC). In others, school systems in impoverished areas have begun to participate in EPSDT in order to ensure that developmental and physical problems of low-income children are detected and treated early before they interfere in the education process. Finally, some state Title V agencies have used the EPSDT assessment package to establish a standard for improving the scope and quality of health assessments provided to all children seen at Title V-funded clinics.

C. The achievements of title V

The Title V Maternal and Child Health and Crippled Children's Programs represent the nation's most enduring commitment to the cause of maternal and child health. In 1979, state health agencies combined nearly $400 million in Title V appropriations with Medicaid and other federal, state and local funding to provide health services to 13 million [12] of the nation's poorest and most medically underserved mothers and children. Title V agencies have used their funds to provide comprehensive prenatal and delivery services to high-risk women at Maternity and Infant Care Projects; health examinations and treatment at Children and Youth Projects; complete dental care at special dental care projects; intensive care services for high-risk infants; and specialized diagnostic and treatment services for children suffering from a wide range of crippling physical ailments.

The Title V programs, with their special maternal and child health mission, have also served as a galvanizing and targeting force for these vulnerable populations. Title V-funded clinics are, in many states, the primary providers of essential health benefits, including WIC, EPSDT, genetic screening, family planning, and adolescent health and immunization services. In other states, Title V agencies have worked closely with health planning agencies to ensure that state health planning efforts adequately reflect the needs of mothers and children. Finally, many Title V agencies have played an important role in setting standards and training maternal and child health personnel.

Title V maternal and child health projects, especially the comprehensive Maternity and Infant Care and Children and Youth Projects, have been noted for their impact on the populations they serve,[13] and Crippled Children's clinics have gained national respect for the quality of their medical work.

There have been problems in the administration of Title V, most notably because the program's vague mission has allowed many states to expend funds in a non-accountable fashion without improving service delivery to underserved populations. However, the program has been beneficial. These strides have been possible in large part because of Congress' longstanding commitment to a special legislative authority that focuses exclusively on maternal and child health and harnesses an array of maternal and child health resources to meet mothers' and children's unique health needs. Without that particularized legislative focus, however, those needs are especially vulnerable because of the large financial demands of other populations who need far more extensive and costly actue and longterm care services.

Indeed, although children comprise nearly 50 percent of the Medicaid population, they use only about 19 percent of the program's dollars.[14] In the absence of a continued maternal and child health focus, there is a substantial likelihood that increasingly scarce public health funds will be directed away from these silent populations to meet the growing demands posed by institutional health care providers.

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[12] PHS, Comprehensive Report—Services, Expenditures and Programs of State and Territorial Health Agencies, fiscal year 1979 (p. 58).

[13] Davis and Schoen, "Health and the War on Poverty," (Brookings Studies, 1978). See generally, Chapter 5.

[14] Data on the Medicaid Program, op. cit., at p. 65.

III. THE IMPACT OF THE ADMINISTRATION'S COSTSAVINGS PROPOSALS ON MATERNAL AND CHILD HEALTH

A. Description of proposed reductions

The Regan Administration has provided this Committee with a series of ambiguous costsavings proposals in the area of health. Essentially, the Administration proposed that Congress take the following actions:

Place a cap on the Medicaid program and reduce expenditures for fiscal 1982 by $1 billion. A formula for distributing the funds has not been finally resolved. But federal funding would be kept to a level of $100 million below the spending for the current fiscal year.

The Administration would allow a 5 percent increase in federal spending during fiscal 1982 with an adjustment for inflation in subsequent years.

The Administration recommends that a cap be accompanied by "increased flexibility" to the states, although that flexibility has not yet been defined for the Committee.

Totally repeal Title V, along with approximately 25 other targeted public health programs and replace them with 2 general purpose block grants to the states. Each state in fiscal 1982 would receive 75 percent of the funds that currently flow to the states, or entities located within that state, no matter what the state's unmet health needs are and regardless of how seriously the state is affected by the Medicaid cap.

B. The proposed medicaid cap

Several serious consequences would flow from the Administration's proposed cap on Medicaid:

First: Guaranteed coverage under the program will be threatened, and over 20 million beneficiaries—children, pregnant women, and aged, blind and disabled persons—could be left without a health insurance guarantee for essential medical services. Thirteen million Medicaid-eligible children would thus be vulnerable.

Second: State Medicaid programs, already operating under severe restrictions, would be further reduced beyond even minimum acceptable levels.

This year, 28 states have already reported that they are considering, or have already made, drastic program reductions. Some of those reductions include:

Proposed elimination of the program in Oregon and Alabama.

Total elimination of nearly all optical Medicaid services in Montana, including drugs, intermediate nursing home services, eye examinations, clinic services, speech and occupational therapy, hearing aids, psychological services, eyeglasses, and dental services.

Severe reductions of coverage for hospital care in Maryland (allowing 20 days per stay), Tennessee (14 days per year), Utah (26 days per year), Alabama (20 days per year), Kentucky (10 days per year), Mississippi (12 days per year), and West Virginia (30 days per year). Maryland hospitals that provide specialized services to high-risk infants require hospital care beyond that which is allowed under the state's Medicaid program. Increasing numbers of hospitals in Maryland are refusing to admit hgih-risk mothers and infants for fear they will require care beyond the amount that Medicaid allows.

Elimination by New Hampshire, West Virginia, and Washington State of their medically needy programs, which provide Medicaid for families rendered indigent by the cost of catastrophic medical expenses.

Severe restrictions on outpatient hospital and physician care in Pennsylvania, Mississippi, Tennessee, Utah, and Alabama.

Costsharing requirements on preventive health services, most notably prescription drugs, in Alabama, Connecticut, Indiana, Iowa, Kansas, Kentucky, Minnesota, Mississippi, Missouri, New Hampshire, Utah, Virginia, Washington, West Virginia, and Wisconsin.

Given the enormous Medicaid reductions that states are considering, or have already implemented, they have almost nowhere left to cut without eviscerating the program. Past cutback trends indicate that once states have reduced their services packages to skeletal proportions, they will then substantially cut back on the categories of beneficiaries covered. Of the mothers and children presently covered by Medicaid, nearly 1 million fall into optional coverage categories. These beneficiaries may be among the first to be eliminated from Medicaid if a budget cap is implemented.

Who are these "optional" groups?

A woman in Alabama, pregnant for the first time, whose total monthly income is less than $89.

A child in Washington State, whose parents, working full-time, bring home $5,796 a year.

Third: The public and inner-city hospital and clinic system, on which millions of Medicaid beneficiaries depend for both hospital and outpatient care, will be fundamentally threatened.

Public and voluntary hospitals and clinics located in urban areas rely heavily on Medicaid to finance services, available not only to Medicaid recipients but also to the millions of persons served by the public health system who have no health insurance at all.

The public health sector is already facing a crisis in health care financing, and a cap on Medicaid will serve to heighten the disaster. From 1975 to 1977, 231 hospitals serving the poor throughout the country closed or relocated. This phenomenon has been especially acute in northeastern and midwestern central city areas inhabited by large numbers of low-income families. Of 326 hospitals located in 18 northeastern and midwestern cities studied over a several year period,[15] 95—or 30 percent—had closed by 1977. These closures appear to have occurred disproportionately in the most isolated and medically underserved neighborhoods in each city. The closings, moreover, have had a profound impact on the availability of employment in these neighborhoods.

As Medicaid funds grow scarcer, therefore, essential health services for the poor will disappear. Moreover, in order to finance the remaining health care institutions that serve the poor, state and county revenues will have to be substantially diverted to health costs, and privately insured patients will have to absorb the cost of uncovered health care costs through higher rates. The state of Maryland estimates a 25 percent rise in health insurance rates as a result of the cap.

Fourth: The increased program flexibility to states which a cap would provide will threaten states' continued commitment to the essential primary and preventive services which mothers and children need.

As institutional health care costs increase, states will be forced to adjust their limited Medicaid programs to meet the continuing need for inpatient and institutional care services at the expense of primary and preventive health care. To accommodate rapid inflation in institutional care costs, states may be forced to restrict access to primary and preventive services and will eliminate from Medicaid high risk families in need of basic health care.

Ultimately, limitations on the availability of preventive health services have a profound effect, not only on beneficiaries' health, but also on state health budgets. Repeated studies on cost-sharing, for example,[16] have demonstrated that by imposing costsharing requirements on basic health services, states have actually forced beneficiaries to go without essential health care until health problems became acute and institutionalization was required, thereby raising the actual cost of a state's overall Medicaid program.

If a state attempts to prevent this shifting of Medicaid utilization patterns by also limiting access to institutional services, the cost of uncovered care will simply be absorbed by localities and private insurers whose rates will increasingly be forced to reflect the cost of serving the uninsured.

Fifth: Limitations on access to Medicaid may affect the general public health.

As health care programs for the nation's disadvantaged shrink, the possibility of widespread disease increases. Indeed, revealing statistics from California indicate that as increasingly scarce health dollars force states to leave greater numbers of persons without essential health services, the incidence of communicable disease rises dramatically. In Orange County, California, where restrictive health care policies left thousands of persons without basic health care, public health data in 1977 showed:

A 57 percent increase in tuberculosis.
A 47 percent increase in salmonecillosis.
A 14 percent increase in infectious hepatitis.
A 153 percent increase in syphillis.[17]

C. The Proposed Repeal of the Title V Maternal and Child Health and Crippled Children's Programs: If the Administration's proposed repeal of the Title V program is adopted by this Committee, the already critical situation created by the proposed medicaid cap will be worsened for several reasons:

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[15] Sager, Alan, "Urban Hospital Closings in the Face of Racial Change", (Testimony to the Subcommittee on Health, Committee on Ways and Means [sic] United States House of Representatives, 14 March 1980).

[16] Roemer, et. al., "Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish", Medical Care (Vol. 13, No. 6, June, 1975) at p. 457. Helms, et. al., "Copayments for Medical Care: The California Medicaid Experience", Rand Corporation.

[17] Dallek, "Health Care for Undocumented Immigrants: A Story of Neglect", Clearinghouse Review, August-September, 1980.

First: The Administration's proposed bloc grant scheme will eliminate a separate legislative authority for, and focus on, mothers and children, thereby further endangering their access to essential health services.

The health care needs of mothers and children are unique and deserve special attention—a fundamental public health tenet recognized by Congress since 1935. Mothers and children require a special group of primary and preventive services, as well as health-related support services; these services are often the most vulnerable in a cutback situation, however. The vulnerability of the services is compounded by the fact that the political voice of mothers and children is small and often not heard when program cuts are made. If Title V is repealed, then the agency major function to represent the cause of maternal and child health in the state health budget process, and in service delivery, will be fundamentally threatened. The continued existence of a separate maternal and child health authority within each state will be left to the political process, where mothers and children historically have not fared well.

Second: There bill be no guarantee of at least a minimum commitment of funds and services in every state to maternal and child health.

A general purpose bloc grant, as envisioned by the Reagan Administration, permits states to spend their funds on a great variety of health purposes. There is no guarantee that adequate funds will be committed to maternal and child health services that are crucial to the well-being of these groups. Many of the services funded by the present program are delivered in areas that have no other maternal and child health resources.

Third: A general purpose health bloc grant with no specific performance criteria or reporting conditions will mean a complete loss of program accountability.

If funds are disbursed to the states for a variety of program purposes, without any performance criteria or specific reporting requirements, the federal government will have no way of verifying whether hundreds of millions of dollars in federal funds are being spent in ways that work to improve the health status of mothers, children and others who depend on the public health system.

In sum, we believe that a cap on Medicaid, accompanied by a repeal of Title V and the creation of a general purpose health grant in its place, will spell the undoing of over a half century of public commitment to the cause of maternal and child health. A cap on Medicaid will virtually mean the end of an insurance program that has benefitted millions of families. A repeal of Title V, in addition, is likely to mean the end of special efforts to secure a portion of scarce health dollars for mothers and children and to develop resources to meet their needs.

IV. A MOTHERS' AND CHILDREN'S AGENDA FOR COSTSAVINGS AND PROGRAM IMPROVEMENTS

We strongly believe that the proposed large-scale reductions in the federal health budget will ultimately prove to be extremely costly to the state and to current program beneficiaries. Across-the-board program reductions not targeted to controlling the high-cost elements in the nation's health care system will simply shift the fiscal burden to the states and localities. Indeed, such wholesale reductions will expand states' and localities' burdens, since more and more disadvantaged persons may be forced to go without basic health care while overall health care costs continue to rise more rapidly than the current rate of inflation.

If program reductions are to be made, then Congress must commit itself to making costsaving changes that encourage fiscally sound health care practices while preserving access to health care. We believe that the following directions are worth exploring as ways to both save money and promote better health care for the poor.

Directions for change

A. Medicaid.—We believe the major challenge facing this Committee in controlling Medicaid costs is to develop a plan that controls the cost of institutional care while enouraging the use of primary and preventive health services.

1. Altering the medicare and medicaid reimbursement methodology for hospitals and longterm care institutions.

Reimbursement for hospitals, skilled nursing facilities, and intermediate care facilities currently accounts for approximately 70 percent of the Medicaid budget. Inflation in institutional care costs is the single greatest factor in the growth of both the Medicare and Medicaid budget.

A major reason for the high rate of inflation for institutional care services is the retrospective cost reimbursement methodology which the Medicare and Medicaid programs require. Retrospective cost reimbursement means that Medicare and Medicaid must essentially pay for the cost of institutional care without controls to assure more fiscally sound institutional expenditure practices. Currently, hospitals

are paid for the cost of the services they provide, even if those services could have been provided in a less costly fashion.

Congress should consider abolishing the current retrospective cost-based accounting system for institutional reimbursement under Medicare and Medicaid and permitting states to negotiate reimbursement rates with institutional providers on a prospective basis. States would be able to establish rates by institution class and size and by the volume of patients served and could thereby take into account the greater costs incurred by public institutions because of the number of patients they serve who are not covered by insurance.

A prospective reimbursement system would have several advantages. First, it would encourage more modest institutional growth by limiting in advance reimbursement for the cost of institutional care. Second, institutions would have an incentive to control cost, since they could be permitted to retain the difference between the prospective rate and the costs incurred. Third, the needs of special classes of institutions, such as public hospitals, could be taken into account in establishing reimbursement rates, thereby providing these facilities with a firmer financial footing. *Finally*, by eliminating retrospective budgeting, both Medicare and Medicaid might be able to save substantially on the amounts spent by both programs on provider preparation, and admininstrative review, of extensive cost reports.

2. Encouraging provision and utilization of primary and preventive health services.

Repeated studies have shown the beneficial impact on health care costs of adequate access to primary and preventive health care, especially in the case of prenatal and early childhood care. We therefore recommend that this Committee explore the following reforms:

a. Encourage greater physician participation in medicaid.—Currently, many Medicaid recipients rely heavily on costly hospital emergency rooms for basic health care because of the lack of physicians who are willing to participate in Medicaid. Physicians overwhelmingly report that the major reason for their failure to participate in Medicaid is the exceedingly low reimbursement rates paid by states. Often a state's rate of Medicaid reimbursement is a fraction of the Medicare program's reasonable charge reimbursement rate for the same service.

This Committee should consider requiring states to reimburse physicians under Medicaid at a rate that at least equals the reasonable charge rate of reimbursement under the Medicare Part B program. Higher physician reimbursement rates would help encourage greater physician participation and reduce beneficiary dependence on more costly emergency room care.

b. Encourage more comprehensive coverage of abmulatory health services, including clinic services.—Many states erroneously believe that costsavings can be achieved under Medicaid by limiting coverage for preventive services. One common limitation is a prohibition on services rendered by freestanding health clinics, the major source of economical and preventive health care for the poor.

This Committee might consider providing states with fiscal incentives for offering preventive health services by substantially increasing states' federal medical assistance percentage for non-institutional care services.

3. Creating alternatives to institutional care.

A number of reports on longterm care estimate that a substantial proportion of residents in costly longterm care facilities inhabit those institutions because there is no other way for them to receive the relatively modest amount of services they require. States could provide necessary services to these persons in a far less restrictive and less costly outpatient fashion, but many states currently do not include enriched home health services in their Medicaid programs.

We therefore recommend that the Committee consider coverage for increased home health care, especially for persons for whom the value of necessary home health care would be less than the cost of institutionalization. This change would not only encourage more fiscally sound utilization of skilled and intermediate facility services but would also provide a far more humane treatment alternative for program beneficiaries.

4. Costsharing for ambulatory care services.

Current Medicaid law protects categorically needy recipients (essentially those persons who also receive aid under federal cash assistance programs) from costsharing requirements for physician and hospital care and other mandatory Medicaid services. Any copayments which are imposed on the categorically needy (for optional services, such as prescription drugs) must be nominal in amount, not to exceed 5 percent of the payment the state makes for services. The Reagan Administration, however, proposed to allow states to impose costsharing requirements on all Medicaid beneficiaries for all services.

To understand the devastating impact that wholesale costsharing would have on beneficiaries' access to essential health services, take, for example, the case of a pregnant woman living in Alabama with two children on approxiamtely $150 per month. Under current federal costsharing guidelines, physician, EPSDT, and hospital services for the mother and her 2 children would be provided free of charge. She would therefore be assured of adequate prenatal care, a safe hospital delivery, and primary health care for her two children.

Under the Administration's proposal, however, the picture would be quite different. The woman's costsharing obligations could easily add up to the following:[18]

Hospitalization (3 days)	[1] $9.00
Services of attending physician	[2] 3.00
EPSDT health assessment and treatment for each child	4.00
Eyeglasses provided through EPSDT for one child	3.00
Dental care for the other child	3.00
Sudden emergency physician visits for each child because of winter flu and ear infections	2.00
Total	24.00

[1] $3.00 per day, assuming a normal delivery. If the delivery were complicated and additional hospitalization was required for the mother and her infant, the cost would be much higher.

[2] Assuming the physician offers a prenatal/delivery care package and does not charge separately for each service.

Out of the woman's $150.00 monthly income, an astonishing 16 percent at a minimum might be spent on medical care in a month. Extensive costsharing requirements might well deter her from obtaining most of the above services, but at an incalculable cost to herself, her children, and ultimately, to the state itself.

We strongly oppose the imposition of costsharing requirements on program beneficiaries. If costsharing prohibitions are to be imposed, however, we urge that this Committee prohibit states form imposing any costsharing requirements on ambulatory services, since these are precisely the services that families should be encouraged to use. Congress should furthermore establish cumulative maximum limits on costsharing so that no family is forced to use more than 5 percent of its monthly income to meet copayment requirements.

Finally, we strongly urge that this Committee except pregnant women and children from any costsharing obligations. To force an indigent mother to have to choose between food or medical care for her children raises more questions beyond the longterm fiscal wisdom of forcing the poor to forego basic services. We believe, quite simply, that the choice is one that no civilized society should ask a mother to make.

5. Prudent buyer programs for health services.

A frequently discussed reform possibility is enactment of a "prudent buyer" program under Medicaid. We have deep concerns about prudent buyer provisions that would allow states to restrict beneficiaries' access to providers of direct health services, including hospitals, clinics, and physicians.

Prudent buyer restrictions are especially serious in the case of hospital care. By their nature, public hospitals may be far more costly than private institutions beause of the number of uninsured patients they serve. In a prudent buyer bidding situation, these facilities would be at a distinct disadvantage becasuse of their heightened operational costs. Furthermore, if a prudent buyer contract is let to a hospital with discriminatory staff privilege policies, there is a substantial likelihood that physicians who serve the poor will not be able to admit their patients to a prudent buyer facility. Medicaid beneficiaries would therefore be left without any source of hospital care.

We do believe, however, that prudent buyer provisions for indirect health services, including eyeglasses, durable medical equipment, laboratory services, and so forth, may be a desirable costsavings device and should be explored further.

6. Preserve the Committee's commitment to EPSDT.

We believe that the EPSDT program, with its mandate to do more than simply pay medical bills, continues to be an essential and cost-effective health program model for the 11 million children who currently receive Medicaid. It has been indicated, however, that some thought is being given to repealing EPSDT's affirmative program obligations of the EPSDT penalty statute.

We urge that the Committee consider the rationale for establishing EPSDT in the first place, and Congress' earlier decision in 1967 to require more than a simple

[18] Utilizing current costsharing guidelines specified by federal regulation, 42 CFR § 447.54(a)(3).

health financing program for Medicaid-eligible children. We believe that repealing the service requirements of the penalty statute would have serious consequences. We therefore strongly urge the Committee not to repeal the penalty statute and undo the years of work which states have invested in implementing its provisions.

B. Health program consolidation.—The critical maternal and child health task for this Committee, as it identifies potential health consolidation plans, is to preserve mothers' and children's access to essential health care.

1. Preserve a strong maternal and child health authority.

We believe that preservation of a separate legislative authority for mothers and children, distinct from other health bloc grant programs, is absolutely essential. As federal funds grow increasingly scarce, a strong state voice for mothers and children will be critically important.

The Title V program represents a basis on which to build a separate maternal and child health legislative authority and could be the focus of such an independent authority. We believe that the key elements of an independent authority would include:

An earmarked appropriation to be used solely for provision of maternal and child health services, with some continued state financial matching requirements.

Authority to harness and direct the expenditure of that proportion of any other health bloc grant which represents at least current service obligations for mothers and children under health programs other than Title V.

Responsibility for planning for, and assuring the availability of, essential prenatal, primary, and preventive health services in all areas of a state, utilizing current health resources where they exist and developing new services where they are needed.

Development of minimum standards for basic prenatal and preventive services, so that all mothers and children utilizing service sites developed by the agency are assured of adequate care.

Development of minimum service performance criteria and program reporting requirements that provide the federal government with an assurance that funds are being appropriately spent.

Improvements in the relationship between state maternal and child health authorities and state Medicaid agencies in the administration of child health programs. Specifically we recommend that the maternal and child health authority and state Medicaid agency develop a joint child health plan. The plan would:

Identify current resources.

Measure unmet maternal and child health needs.

Commit program funds to geographic and functional areas where they are needed.

Develop a casefinding plan for all low-income and high-risk mothers and children.

Develop uniform assessment and case management protocols for all providers participating in the program.

Implement minimum program reporting requirements on the numbers of women and children served.

Report on program outcomes, including conditions disclosed and treated.

Finally, we believe that in assessing the impact of the Administration's program consolidation proposals on mothers and children, this Committee should seek answers to several key questions, including:

Will the proposal more effectively deliver maternal and child health services? Will the quality and accessibility of health care be improved?

What type of health system will the proposal create or encourage? Will the proposal place undue emphasis on the public health system, even when alternative, existing resources are available and two-class care could therefore be avoided?

How will program beneficiaries react to the change?

V. CONCLUSION.

We have offered this Committee an analysis of the impact of the Reagan Administration's proposed health budget cuts and have set forth an agenda for reform that would provide costsavings while assuring essential program improvements for mothers and children. We hope that this Committee will use the same methods as it develops its reform package.

Thank you very much.

Statement on Proposed Federal Spending Reductions and Block Grant Funding to States

STATEMENT SUMMARY

1. Title V has been the cornerstone for state MCH and CCS preventive and specialized care serving needy pregnant mothers, infants and handicapped children for the past 45 years.
2. Formula grants through Title V are time tested and have been largely successful as a Federal-State funding mechanism. The block grant design is untested on the scale being proposed.
3. Substantially reduced funding and placement in unrestricted blocks will not assure priority for the MCH and CCS patient populations.
4. Repeal of Title V could by itself produce up to a 30 percent reduction in available funds for state Title V programs.
5. The combination of 3) and 4) above seems an unjust burden to place on those least able already to compete for available health care dollars.
6. Title V supported programs by emphasizing prevention, early detection, and specialized treatment have a high benefit-cost ratio yet continue to receive proportionately less funding for services.
7. The Association submits that Title V should be considered an integral part of the Social Security system and should be retained.
8. The GAO and other recent studies of Title V emphasize the need for maintaining state MCH and CCS units around which other related programs could be consolidated as has already taken place in many states.
9. Title V legislation includes, among other successful features, provisions for a continuing authorization, a state plan, minimum of regulations, ongoing training of health professionals and applied research, and an identifiable administrative unit.
10. The requirement that nationally recognized and accepted medical care standards be utilized as a condition for federal program support should be retained.

Mr. Chairman, members of the Committee, I am Judson Force, President of the Association of State and Territorial Directors of Maternal and Child Health (MCH) and Crippled Children's Services (CCS) programs. The Association appreciates the opportunity to appear before this committee and express our views on the Administration's spending proposals for Title V of the Social Security Act.

The primary purpose of the Association is to assist persons responsible for administering State MCH and CCS programs toward continuous efforts to improve access and quality of vital health services. MCH programs have long demonstrated an emphasis on prevention, health promotion, and ambulatory care to reduce emergency room use and hospitalization. CCS has focused on reduction of long-term disability through provision of specialized diagnostic, treatment, and case management services of high quality. We believe the Title V mandate to be the cornerstone upon which states and territories have been able to build the present "safety net."

This network provides preventive and specialized health services for over three million of the most needy mothers, infants, and handicapped children. Title V has been the predominant expression of Congressional interest in the well being of pregnant women and young children since 1935. It authorizes grants to each state to (1) extend and improve services for reducing infant mortality and otherwise improving the health of mothers and children and (2) for locating and providing diagnosis, medical, surgical and corrective care for children who are crippled or who are suffering from conditions leading to crippling. The legislation provides a time tested Federal-state-local partnership which has kept the needs of mothers and children paramount.

Although it may be in the national interest to reduce Federal spending, there is no evidence to suggest that health services to mothers and children will be enhanced through the proposed policy of unrestricted block grants to states. Congressional approval of the Administration's present HHS block grant proposals could result in as large as a 50 percent reduction of Title V program support through the combined loss of Federal and State matching funds. To combine spending cuts with the repeal of Title V would place the patient populations served by this entitlement in double jeopardy. The MCH and CCS delivery system could be devastated by any sizeable displacement of the present state role.

Historically, women and children have had great difficulty in competing for health care dollars at all levels of government. Examination of MCH and CCS funding trends over the years indicates that they continue to represent a disproportionately small share of health care resources compared to other groups. However, funds spent in this area have produced dramatic results made evident in lower infant and maternal mortality rates, reduced incidence of metal retardation, and improved quality of life for millions of children. Hundreds of thousands of infants

and children treated under Title V supported programs have become productive adults rather than dependent charges upon society. For too long these programs have not been sufficiently funded to reach many needy mothers and children. The humanitarian and economic implications are compelling.

Mr. Chairman, the Association recommends that Title V of the Social Security Act be retained. The nation's economic future and security is very much dependent on the health status of its women of child bearing age and their offspring. A Congressional mandate for mothers and children seems appropriately included as part of the Social Security system—a system that continues to be the major national conscience and resource for those population groups in our society that can least compete for basic medical and health care needs.

It is especially urgent that in a period when resources are to be reduced and redistributed that advances made through improved state and local organization and delivery of preventive and specialized care not be lost. Many states are presently using the Title V mandate as the basis for consolidating programs focused upon mothers and children. In several states there already exists a block of programs administered by Title V Agencies including MCH, CCS, SSI to Disabled Children, Sudden Infant Death Syndrome, Genetic Disease, WIC, Adolescent Health, and Family Planning Services. A recent Comptroller General's Report to Congress entitled, "Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome," recommended that Congress consolidate interrelated Federal programs and bring them under a single State MCH Direction. Other recent studies of Title V programs all emphasize the continued need for a strong state MCH and CCS focus.

Mr. Chairman, the Association would like to note certain legislative features of Title V that have enabled states to successfully meet new and increasing program responsibilities, namely (1) a continuing rather than short term authorization, (2) an individual state plan through which states and local differences in needs and resources can be expressed, (3) a minimum of Federal regulations and wide latitude for states to set their own priorities, (4) basic program support through formula and special project grant authorities, (5) ongoing training of professional health personnel and applied research in maternal and child health issues of national importance and (6) an identifiable administrative unit within State government to be accountable for MCH and CCS funded activities.

In closing, perhaps one of the most troubling aspects of the Administration's block grant design is the elimination of existing Federal maternal and child health care standards. These standards, a present requirement for federally financed services, have been based upon national standards formulated by the medical profession as a whole. It is important that states provide services consistent with nationally recognized and accepted professional medical judgment regarding the types of services which are essential and appropriate for mothers and children with various kinds of health problems.

THE FEDERAL GOVERNMENT AND HEALTH CARE SERVICES FOR HANDICAPPED CHILDREN

(Summary of Testimony by Richard P. Nelson, M.D.)

The Health Services Block Grant proposal will adversely affect the capabilities of states to serve the health needs of handicapped children.

1. The abolition of Title V of the Social Security Act will:

Result in the diminution of state programs charged with serving this population of children.

Eliminate "matching" requirements that currently result in a 3-fold increase in resources compared to the basic Title V formula grants.

Inject handicapped child programs into competition for funds at a state level with agencies that have vastly more powerful political constituencies.

2. The reduction or elimination of the Office of Maternal and Child Health in DHHS will:

Reduce the nation's capability to provide technical assistance and consultation to states and target resources for emergent concerns.

Eliminate training of health care professionals necessary to serve handicapped children in the community.

Abolish directed applied and clinical research necessary to improve the identification and treatment of these children.

A REASONABLE AND JUST INVOLVEMENT

Children with chronic illness or disability are a valuable resource to our nation. They are visable evidence of the fragile nature of our well-being. Their parents and advocates have pursued necessary health care and social services to maintain the integrity and self-capacity of the family.

Less than a century ago handicapped children were among the hopeless in American communities. Medical treatment could rarely restore lost function from withered extremities or unremitting disease. Charitable organizations struggled to provide adequate care and services. Families suffered serve emotional and financial burdens. The compassion of citizens induced the government to establish specialized institutions and hospitals, generally funded with appropriations by State legislatures.

The Federal government's role in assuring services for handicapped children emerged when the Children's Bureau was created in 1911. The Bureau focused Federal efforts on behalf of children.

In 1935 Title V of the Social Security Act became landmark legislation. The Act enabled each state to organize a crippled children's services (CCS) agency for locating and providing diagnostic and treatment services to handicapped children.

In 1979 these agencies: Directly served approximately 1.2 million children and youth. Expanded $86.0 million in Federal formula grants to $274.9 million by matching State and local appropriations for services.

A representative example of the effectiveness of State crippled children's services agencies it the Minnesota scoliosis program. In each of the past five years 225,000 children in grades 5-9 have been voluntarily examined in their schools for curvature of the spine, a condition that sometimes progresses to create severe deformity. Since its inception the scoliosis program has documented a dramatic reduction in the number of children requiring costly surgery as a benefit of early recognition and treatment.

The Health Services Block Grant proposal will adversely affect the capabilities of states to serve the health needs of handicapped children.

1. The abolition of Title V as a result of the block grant legislation will thrust services of states for handicapped children into jeopardy:

States will no longer have an obligation to maintain a CCS entity within their executive structures, thereby compromising public health services for handicapped children.

States will no longer be required to "match" Federal grant funds with State or local funds, thereby diminishing public health resources for these children.

The demand for public health dollars in most states, currently subject to unprecedented budgetary pressures, will undoubtedly reduce the level of block grant funds intended to support services now provided by the Title V formula grants.

2. The reduction or elimination of the Office of Maternal and Child Health in the Department of Health and Human Services as a result of the block grant legislation will reduce the nation's capability to assure health services to handicapped children.

No Federal agency would have the capability to provide technical assistance and consultation to states regarding the health needs of handicapped children.

The Federal government would have no mechanism or designated funds to target on emergent issues important to handicapped children.

The training of health care professionals crucial to services for handicapped children, now funded by Title V at schools of public health and university affiliated facilities, would be curtailed or eliminated.

Federal support of applied and clinical research important to improving services to handicapped children would be abolished.

The intent to control burgeoning Federal spending should not cast aside over 70 years of thoughtful Federal involvement in health care services for handicapped children. Justice for these children will not be served by budgetary expediency. Let us not further validate the conclusion of Luther Burbank:

"If we had paid no more attention to our plants that we have to our children, we would now be living in a jungle of weeds."

STATEMENT OF DR. ROBERT L. GOLDENBERG

I came to Birmingham, Alabama, five years ago, to teach medical students and provide obstetrical care at the major referral center for pregnant women and newborn infants. At that time, because prenatal care and appropriate hospitalization were less available to the poor than they are now, pregnant women and newborn infants died or were damaged in extraordinary numbers. Many of these

tragedies, such as mental retardation and cerebal palsy, could have been prevented by assuring access to appropriate medical care.

Looking at this problem with many other concerned citizens, it was obvious that it was only the state's Title V Maternal and Child Health agency which had the potential power to make the necessary changes. I joined that agency nearly four years ago and since that time we, working closely with the private medical community and the state's universities, have provided prenatal care to virtually every woman in need in Alabama. We have reduced the number of women delivering at home to only a small fraction of the number of just four years ago. In the process, infant mortality in Alabama has been reduced by nearly a third in just three years (Table 1). This means that nearly 300 infants which would have died only three years ago now survive. All available estimates show a marked reduction in handicapping conditions as well.

I want to emphasize that these changes did not occur by chance. They occurred because there was a single state agency, the Title V Maternal and Child Health agency, which was able to use its own and help target other resources toward achieving a reduction in infant mortality. Recent similar success stories can be seen in state after state and nearly always the Title V Program has been in the lead.

Despite Title V's achievements, the Administration nontheless proposes to totally eliminate the program and bloc it with 25 other public health programs. Funding for all programs would be reduced by 25 percent of the current expenditure levels. The resulting bloc would be untargeted by popoulation and devoid of requirements to assure programmatic responsiveness to specific population needs. This proposal is further complicated by the Administration's proposed cap on Medicaid.

I am gravely concerned about the demise of Title V because it would mean that there would no longer be federal funds specifically targeted to improve the health care of pregnant women and infants. Without this targeting at the federal level, funds desperately needed for women and children, and certainly intended by Congress to be used for health care for women and children, will very likely be used to satisfy more vocal and more politically active constituences. Two examples for Alabama come very much to mind. First, faced with a threatened reduction in funds for one of the optional Medicaid nursing home programs, the state's nursing home operators deposited hundreds of elderly, often catheterized, people in wheelchairs and stretchers on the steps of the state capitol. The administration backed off the proposed reductions, but within a short time Medicaid funds for prenatal care for women and hospital care for infants and children were reduced.

As another example, I note that the proposed bloc grant which is to include Title V funds also will include mental health funding as well. In Alabama, the federal judiciary has essentially taken over the mental health system and has mandated increased spending in that area. Given the current limitation on funds available to the state, one can easily project a sequence of events in which funds originally intended by Congress to reduce infant mortality and handicapping conditions will be virtually comandeered by the federal court system to be used for mental programs. It is therefore ironic that while one branch of federal government is telling us "here is the money—set your own priorities", another is directing the state to spend funds in specific areas.

In addition to the loss of focus on mothers and children which the Administration's consolidation proposal would cause, the proposed cap on Medicaid would significantly decrease our ability to maintain the progress in maternal and child health which our state has demonstrated. Since 1965, infant mortality rates have fallen from 30.7/1000 to 14.3/1000. We attribute a large proportion of this reduction to the vital relationship established between Title V-funded prenatal clinics and Medicaid.

As you may be aware, the Alabama Medicaid program, as in many states, provides no assistance for prenatal or delivery care for the married poor. In several other states, prenatal care for the first pregnancy is not covered at all. As you may also be aware, Medicaid alone does not assure access to adequate care. Many physicians will not accept Medicaid as payment for prenatal and delivery services. In fact, in Alabama, we estimate that only one-third of indigent pregnant women are covered by Medicaid and, of these eligible women, nearly two-thirds cannot receive prenatal care in a private physician's office. In many counties, however, physicians who will not provide office prenatal care to Medicaid-eligible women will provide hospital delivery care.

The system that has developed across Alabama, therefore, involves utilization of local Title V programs to provide basic prenatal and infant care and family planning services to all poor women and their children whether Medicaid-eligible or not. Hospital care by private and university physicians and other personnel supported by Medicaid, state, and local funds complete the system. Each federal program is

essential because of the weakness of the other. Title V provides prenatal care to low-income pregnant women who are ineligible for Medicaid, while Medicaid provides critical health insurance monies that allow our local clinics to arrange adequate hospital care for their patients.

In many counties in Alabama, the only agency that is available to provide prenatal care for poor women and follow-up care to their infants is the Title V agency. Without this agency, in many areas, even the availability of Medicaid funding would have little effect because there would be no one available to provide prenatal services. As an example, in Jefferson County, Birmingham, Alabama, the local Title V agency provides prenatal care for nearly 5,000 women per year. Hospitalization is arranged through county, university, and private hospitals, and is paid for by a combination of Medicaid, Title V, local and state funds.

Finally, Title V has from its inception placed a major emphasis on overall prevention efforts, including educational programs for providers of medical care for women and infants, patient education emphasizing early prenatal care, decreasing alcohol and tobacco consumption, immunization, outreach, and follow-up care—all important components of our successful program to reduce infant mortality.

Therefore, for women and children in Alabama, Title V has provided the glue which holds together a very tenuous but working medical care system for poor women and children. Removing the Medicaid entitlements for the women and children currently served will likely have a profound effect on the health care available to poor women and children in Alabama. At the same time, not to ensure that there will be a Title V program to advocate for women and children and to provide a minimal level of care would be disastrous. Saving money is one thing. Destroying a system which has grown up over decades and is now showing impressive yearly reductions in infant mortality and handicapping conditions is clearly another.

Recommendations for change

The progress we have made on maternal and child health in Alabama has been dramatic, in relation to both the health status of our mothers and children and the fiscal health of the state. Each damaged child requiring institutional care will require $500,000–$1 million support over his or her lifetime. We estimate that over the last 3 years we have been able to reduce the number of children who would require such care by 100 or more children per year, at a cost of about $150 per mother for prenatal care. We further estimate that for every dollar that Alabama has spent on prevention through Title V and Medicaid, the state has saved between $5 and $10. This does not even take into account the 300 babies who survive each year now and who would not have 3 years ago. It also does not take into account the 300–400 babies who would have been mildly retarded only 3 or 4 years ago. Finally, these statistics do not begin to capture the changes that these programs have made in the lives of low-income pregnant women who, until a few years ago, went from hospital to hospital in labor, or had their babies at home unattended, because they could not pay their hospital bills.

In order to maintain and preserve these advances, I recommend that the Committee do the following:

1. Preserve a separate legislative authority for mothers and children.—Title V has been vital to the improved health care of mothers and children and represents a sound base on which to develop strong state maternal and child health efforts.

2. Develop sensible programmatic requirements for state MCH authorities that (a) emphasize delivery of needed services; (b) encourage thoughtful program planning; (c) consolidate a variety of smaller programs that also provide funding for MCH services (such as SIDS, genetic screening, adolescent pregnancy, and so forth); and (d) eliminate unnecessary program development or reporting requirements.—I believe that these four programmatic requirements are important for assuring both state accountability and increased state efficiency in the provision of health services for mothers and children.

When I speak of consolidation of programs and reduction of unnecessary regulation, I want to emphasize that I do not mean a decreased emphasis on service delivery or program accountability. What I mean is best illustrated by the following:

Title V Maternal and Infant Care Projects, by statute, prohibit services to children over the age of 1, thereby fragmenting care of families served by the projects.

Improved Child Health grants made under Title V by the Department of Health and Human Services are restricted by geographic location and have led to the inefficient utilization of resources.

3. Maintain a central federal maternal and child health authority that provides program guidance, technical assistance and maintains reporting systems.—A strong federal presence and guidance are important both to assist state health programs in

policy and administrative issues and to assure that states spend their funds in an accountable fashion.

4. *Continue the Medicaid entitlement and do not implement a cap on the program.*—Currently, mothers and children fare poorly under Alabama's Medicaid program, whose funds are heavily directed to meet institutional care costs. As pointed out earlier, mothers and children already have such minimal services under Medicaid that a cap would be devastating.

Thank you for providing me this opportunity to testify.

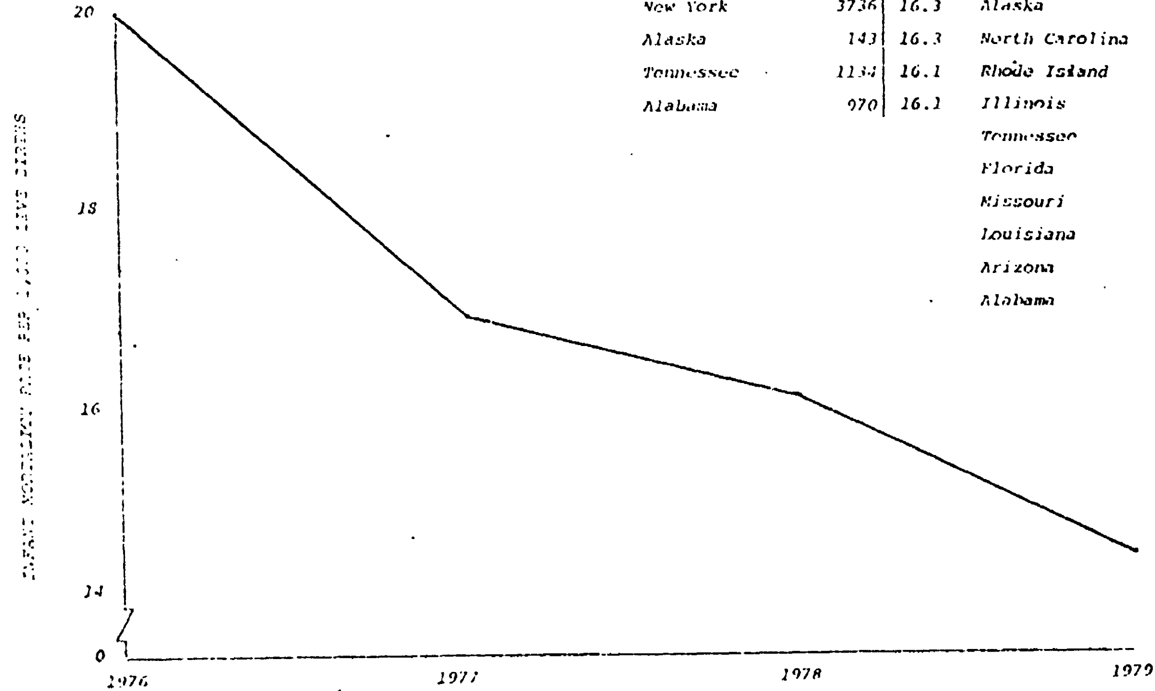
INFANT MORTAL! I A. .BAMA TABLE

1976	#	Rate
Dist. of Columbia	478	24.0
Mississippi	869	20.8
Alabama	1134	20.0

1977	#	Rate
Dist. of Columbia	495	23.9
Louisiana	1362	18.0
South Carolina	856	17.8
Mississippi	784	17.3
Alabama	1036	17.0

1978	#	Rate
Dist. of Columbia	440	23.1
South Carolina	871	18.5
Louisiana	1343	17.8
Mississippi	778	17.1
North Carolina	1347	16.3
New York	3736	16.3
Alaska	143	16.3
Tennessee	1134	16.1
Alabama	970	16.1

1979	#	Rate
Dist. of Columbia	392	22.6
Mississippi	819	17.8
South Carolina	859	17.2
New York	3661	15.8
Delaware	144	15.8
Alaska	137	15.4
North Carolina	1292	15.3
Rhode Island	186	15.2
Illinois	2750	15.2
Tennessee	1094	15.1
Florida	1811	15.0
Missouri	1165	14.8
Louisiana	1177	14.8
Arizona	671	14.7
Alabama	891	14.3



SUMMARY OF STATEMENT BY GEROLD L. SCHIEBLER, M.D. F.A.A.P.

I. Organizational structure of Children's Medical Services of Florida. The state of Florida has addressed the problem of a diversified system of maternal and child health care through a myriad of federal programs by the development of an organizational structure for mothers and children at a high level within our state government. Through the creation of Children's Medical Services (CMS) we have in fact developed a state-wide based system of care based on the Title V concept of the "crippled child."

II. Programs included under CMS.

III. Success and effectiveness of CMS. The state of Florida's plan for the comprehensive care of children is a working model for other states as well as on the federal level—a high administrative office within the state and federal governments to administer maternal and child health programs and to develop appropriate linkages to all other programs which impact upon maternal and child health. This model has been successful because it has been based on the Title V program and has paid particular attention to standards, quality of care, medical leadership and, above all, the child and his or her needs.

RECOMMENDATIONS

1. Preservation of the Title V Program.
2. Support a maternal and child health block grant approach.
3. Create an organizational structure for maternal and child health at a high level within the federal government.

Mr. Chairman, I am Gerold L. Schiebler, M.D., Chairman of the Department of Pediatrics at the College of Medicine at the University of Florida. The State of Florida has addressed the problem of a diversified system of maternal and child health care through a myriad of federal programs by the development of an organizational structure for mothers and children at a high level within our state government. Through the creation of Children's Medical Services (CMS) we have in fact developed a state-based system of care based on the Title V concept of the "crippled child." It is the Title V program which is the subject of these hearings today, a program which must be preserved and expanded if this country is to continue its commitment to mothers and children.

CMS was developed to create a high administrative position within the state government to serve as an advocate for the child. Expanding upon the crippled children's programs under Title V, its role has been modified to include any condition that might potentially affect the overall well-being of the child. By design this program Office of CMS (originally designated the Division of Children's Medical Services) puts maternal and child health on an equal plane with other health units. The Director of CMS has direct access to the Secretary and the legislature which has allowed us to effectively compete for resources and additional responsibilities. This is indeed significant in that heretofore children's programs and projects were not afforded equivalent visibility, (i.e., program support, funding and personnel).

Actual programs administered by CMS include:

1. The original Title V crippled children's program.
2. The regional children's kidney program, which includes clinics, dialysis centers and transplant centers. (There are two comprehensive children's kidney program centers in the state.)
3. The regional children's cardiac program, including clinics, cardiac catheterization labs, and cardiac surgery centers. (There are four such surgery centers in the state.)
4. The regional rheumatic fever program that includes clinics, a central laboratory center, professional guidance, state-wide education and evaluation and statistical data.
5. Liaison to the Title V pediatric pulmonary program.
6. State-wide perinatal/neonatal programs including transportation, treatment, four year evaluation assessment after the discharge from the neonatal program, and the implementation of state-wide standards. (There are nine centers throughout the state which encompass high risk mothers and children.)
7. Liaison to the perinatal intervention program, where, for example children with handicaps discovered in the four year evaluation assessment are rapidly triaged into the intervention program to minimize their handicap.
8. State wide screening program for biochemical defects including thyroid disease, PKU, galactosemia and maple syrup urine disease.
9. Liaison with state-wide scoliosis screening program.
10. The child abuse program. (There are now five centers in the state.)

11. Regional medics program, involving a state-wide network of clinics. (There are three diagnostic and treatment centers, one at each of the state's medical schools that are linked to the state-wide neonatal biochemical program.)

12. The REACH project. This is a pilot project funded by Medicaid and the Robert Wood Johnson Foundation to bring skilled professionals to rural areas. These professionals live in the rural areas to provide a continuing advocacy of the child's total health care needs and act as a liaison to the educational system. This project allows an increased measure of health care within the community, a decrease in the number of emergency room visits, a decrease in number of days of hospitalization and clinic visits and allows families with these handicapped children to remain in their rural communities rather than feeling compelled to move their families to the centers.

13. Regional diabetes program. This is a network of clinics about the state that involves a summer camp for children with diabetes. There also is a CMS liaison to the diabetes and research education centers. (There are three such centers, one at each medical school. CMS has a member on the state advisory committee advising the three diabetes research and education centers.)

14. A CMS has a liaison to the state-wide cancer program for children. This involves clinics and treatment centers funded by the National Cancer Institute.

15. Supplemental Security Income. CMS is the lead agency for the program.

16. Liaison to the Developmental Disabilities Council on which CMS has a representative.

17. It is also designated as a provider under EPSDT to screen children.

As we look to the future, consideration should be given to many more programs which can be grafted onto CMS, including the MCH component of Title V. I should point out that MCH has made little or no advances in Florida in the past six years whereas the Crippled Children's component has increased its role, function and resources dramatically, which speaks to the value of its present organizational position. In the future we should also consider such items as: a) increased liaison to the school health services program; and b) a Medi-kid program, in which an aliquot of Medicaid funds would be given solely to children's health programs.

As we look back on the effectiveness of CMS, I would like to highlight the following achievements:

1. Decreased fetal mortality rate. For the first time, Florida is now at or below the national average.

2. Decreased morbidity rate.

3. Amalgamation of miltiple local, state and federal screening programs which has decreased the fragmentation of care and increased cost effectiveness.

4. Increased budget for children's programs.

5. As the fulcrum for much child-related legislation and regulation, the following measures have been enacted: neonatal screening programs, neonatal health insurance, regulation of hot water heaters, required pre-school physical examinations, and adoption of handicapped children.

6. Maintenance of the involvement of the private sector at the educational units within the CMS patient care structure even at significantly reduced, below standard fees for the area. This has maintained the best qualified physicians in Florida within the system. There continues to be a need to address the reimbursement system that will allow the continuation of the private sector in its involvement.

7. The CMS allows for relation to education—85 percent of the children in the program are utilized in the educational system relating to Florida's future health professionals. The CMS law in Florida indicates that whenever feasible the CMS progams should work with those centers that educate the future health professionals for children.

8. The establishment of state-wide standards. Ninety percent of the nation's standards for cardiac programs were initially adopted in Florida by rule and regulation. The Title V agency has always been linked to standards that assure a certain quality of health care as opposed to the Medicaid entitlement programs in which the individual may go through a whole series of health providers without any coordination.

In addition to the MCH-CC program so important to child health care in Florida, Title V also provides for the state's University Affiliated Facility at the University of Miami. This program is responsible for the evaluation and care of thousands of handicapped children and for the development of important prevention programs through its training and applied research activities. These efforts require continued support on the national level.

In conclusion, I offer to you the state of Florida's plan for the comprehensive care of children as a working model for other states as well as on the federal level—a high administrative office within the state and federal governments to administer

maternal and child health programs and to develop appropriate linkages to all other programs which impact upon maternal and child health. This model has been successful because it has been based on the Title V progam and has paid particular attention to standards, quality of care, medical leadership and, above all, the child and his or her needs.

We are guilty of many errors and many faults, but our worse crime is abandoning the children, neglecting the foundation of life.

Many of the things we need can wait. The child cannot

Right now his bones are being formed, his blood is being made and his senses are being developed.

To him we cannot answer "Tomorrow."

His name is "Today."

State of Kansas . . . John Carlin, Governor

DEPARTMENT OF HEALTH AND ENVIRONMENT

Joseph F Harkins, Secretary

Forbes Field
Topeka, Kansas 66620
913-862-9360

TESTIMONY

A HEALTHY START - TITLE V PROGRAMS IN KANSAS

PRESENTED APRIL 1, 1981

to

U. S. SENATE FINANCE COMMITTEE

Since 1935, Title V legislation has furthered the Kansas effort to assure a "Healthy Start" for Kansas families by promoting the health of all mothers and children, including the handicapped. The Kansas experience with Title V has been:

- A reliable continuing federal committment of resources in partnership with the state and its communities to promote optimal health for all mothers, their infants and children.

- An annual federal allocation which allows the state flexibility in determining its own programs, unencumbered by federal regulations.

- A sound strategy for targeting federal funds for preventive health and treatment services for persons with handicaps and other high risk mothers and children, the population which can most benefit.

- Within the Kansas Department of Health and Environment the Title V MCH and CC Programs are the "matrix" for adding other federal and state health programs including SSI, WIC, Genetic Disease, SIDS, Family Planning, Newborn Home Visiting, Migrant Health, School Health, and Licensing of Child Care Facilities. Also under this "umbrella" cooperative programs with private medicine and public agencies have been developed for Perinatal Care, Adolescent Pregnancy, EPSDT, and Education of the Handicapped.

- A state unit, responsible for identifying health problems of mothers and children, and for planning and coordinating health delivery approaches has played a significant role in decreasing maternal and infant deaths, diseases, and handicaps in Kansas. It should be continued to assure a Healthy Start for families.

A HEALTHY START - TITLE V PROGRAMS IN KANSAS
APRIL 1, 1981

In Kansas the state's Healthy Start Program of health services for pregnant women, their infants and children, including the handicapped, has been furthered through the use of Title V funds. Within the Department of Health and Environment, Title V funds have provided the matrix for planning, promoting, and coordinating preventive health services, composed of a myriad of federal, state, and community prevention and treatment programs for mothers and children. The 1935 authorizing legislation of Title V has allowed sufficient flexibility for Kansas to determine its own priorities for the use of these funds. Most Kansas programs evolved prior to federal laws and funds. Prime examples include the following:

1. 1915 - Establishment of a Division of Child Hygiene (one of the first in the country) to investigate the causes of infant mortality, to apply measures to prevent and suppress diseases of early childhood and to issue information to parents on the care and rearing of children.

2. 1919 - Licensing of maternity and child care facilities.

3. 1931 - Establishment of the Kansas Crippled Children's Commission for the early recognition and treatment of crippling conditions of children.

4. 1963 - Immunizations for all school enterers.

5. 1965 - Family Planning clinics to be established by the Kansas Department of Health and Environment.

6. 1960'2 and 70's - Laws relating to specific genetic diseases such as PKU, Sickle Cell, Hypothyroidism.

The federal programs which are integrated under the state's Title V authority include MCH-CC, SSI, Family Planning, WIC (Department of Agriculture), and Migrant Health. Kansas also has programs for Genetic Disease and Adolescent Pregnancy funded by a fusion of state, local, and Title V funds, with no separate federal project grants for these programs. At different times in history special federal grants have been administered by Title V in Kansas, such as E.M.I.C. (Emergency Maternity and Infant Care Project) during World War II, a five year Hearing Conservation Project (U.S.P.H.S.) during the 1960's, a Perinatal Casualty Research Project (Title V) 1970 and 1971, and in 1978-80 a Newborn Home Visiting Program funded by the National Center for Prevention of Child Abuse and Neglect.

For the past three decades the Title V Office has worked closely with other state agencies to extend preventive health services to all mothers and children. Since 1951, the licensing of all child care away from

home has been a joint effort of the Department of Health and Environment and Department of Social and Rehabilitation Services. In cooperation with the Department of Education, Title V coordinates school health services in the 305 school districts and in recent years Title V staff have assisted in developing delivery systems for the Title XIX EPSDT Program and for the Department of Education's Child Find and education for the handicapped (94-142). Close liaison exists between the Title V and WIC Nutrition Programs and food stamps, school lunch, and preschool nutrition programs of other agencies.

A concerted effort has been made in Kansas to allocate Title V resources through a system of grants to communities. Local public health departments have mushroomed in Kansas during the past decade increasing from 50 county health departments to 100 of the 105 counties. Although local tax dollars provide the major support for community maternal and child health services, these funds are supplemented by fees collected from private patients, Title XIX EPSDT reimbursements, state funds, and state administered federal grants from Title V, Title X, and WIC.

A good illustration of a cooperative program between Title V and the private sector of medicine is the Statewide Perinatal Program for high risk mothers and sick newborns. Through its efforts a sharp decrease of the state's neonatal mortality rate has occurred, from 12/1,000 births in 1974 when the program was initiated to 7.7/1,000 births in 1979. Close linkages exist with the two branches of the University of Kansas Medical Schools, with the Program of Projects, the special crippled children's clinics, and the University Affiliated Facility.

It has been traditional in Kansas to coordinate Title V program efforts with the private sector of medicine at all levels. Private physicians serve on advisory committees at the state level and provide medical services to the M & I, WIC, C & Y, and Family Planning clinics at the community level. By statute county health departments in Kansas are headed by a physician in that community. In practice in all but three urban counties the health officer is a practicing physician.

The Kansas Healthy Start effort described in the Department of Health and Environment's public information leaflet is further described in a report of the combined activities of Title V and allied programs for 1980, both attached to this testimony.

For more information contact:

Bureau of Maternal and Child Health
Kansas Department of Health
and Environment
Forbes Field
Topeka, Kansas 66620
or your local health department

Fees will very according to the service and the county. Arrangements can be made with your local health department or health provider.

MCH: Maternal & Child Health

Give your child a **healthy start** in life. As a caring parent, you can make this happen by using the maternal and child health services in your community. MCH programs can help your child to be born well and get good health care in those early years.

A **healthy start** for your family can make a difference, too. The preventive maternal and child health programs focus on family members: infants, children, adolescents, and women and men in the child bearing years.

The services are made possible through the Bureau of Maternal and Child Health in coordination with local health departments and other health care providers. Many of these programs are available in your area.

Services for Infants & Children

* HEALTH EXAMS for infants and children who are well, and conferences on their health and development

* IMMUNIZATIONS for children, beginning at two months, to protect them against disease

* NUTRITION SERVICES providing information on infant and child feeding, dietary assessment, counseling and referral

HEARING TESTING to be sure children are hearing as they should

* ACCIDENT PREVENTION information to protect children from unsafe situations

GENETIC DISEASE TESTING of all newborns with consultation and treatment for those who have hypothyroidism and phenylketonuria (PKU), which can cause mental retardation

* SICKLE CELL TESTING information, counseling, and treatment for those requesting it

* CYSTIC FIBROSIS diagnosis and treatment including provision of drugs and equipment

INFANT INTENSIVE CARE in hospitals providing special services for mothers and newborns who are critically ill

* HEALTH EDUCATION about how to keep children well and discussions about their health progress

* SERVICES FOR THE HANDICAPPED and children with crippling conditions which include diagnosis and treatment provided by the Kansas Crippled Children's Program

SPECIAL SERVICES AND ASSISTANCE for children under age 16 who receive Supplemental Security Income benefits

SCHOOL HEALTH services for school-aged children which include screenings on vision, hearing, spine deformity, and other health supervision

Health Care for Adolescents

GENERAL HEALTH SERVICES which focus on concerns of teens such as acne, weight problems, birth control, physical exams, and information on development

MATERNITY AND INFANT PROJECTS which include health and nutritional care, and social services for adolescents and their children from the prenatal period through the child's first year

Services for Families

PARENTING EDUCATION which is part of all MCH services through classes, publications, films, and one-to-one counseling during health exams

* FAMILY PLANNING SERVICES to help assure that every child will be wanted and to insure their health by planning the time of their birth.

PREGNANCY TESTING for everyone requesting it

PELVIC AND BREAST EXAMS which include the pap test and teaching of the Self Breast Exam

CHILDBIRTH CLASSES to prepare parents for the experience of labor and childbirth.

PRENATAL CARE CLASSES and supervision during the time prior to childbirth

FAMILY CENTERED MATERNITY CARE which is encouraged through hospital visits for planning and approving newborn care and delivery units

INFORMATION ON CHILD CARE places which are regulated to insure a safe, healthy environment for children

WIC NUTRITION PROGRAM which provides supplemental food, nutrition education, and health services for infants, children (up to 5 years), and pregnant or breastfeeding women

WOMEN'S CLINICS which provide screenings for diabetes, glaucoma, and high blood pressure.

MIGRANT HEALTH PROGRAM which provides health services to migrant families in Western Kansas

HOME VISITOR programs which provide ideas and support in parenting for families of newborns

PUBLIC HEALTH NURSING visits in the home to address health concerns of families

* CONSULTATION AND REFERRAL for genetic counseling on chronic or genetic diseases

* These services are available for other age groups

PROGRAM HIGHLIGHTS - CHILDREN AND YOUTH - 1980

Kansas Department of Health and Environment

1. Perinatal Statistics

1979 data released during 1980 revealed an increased number of births and a decrease of infant mortality rates.

	Births	Infant Mortality Rate	Perinatal Rate	Neonatal Rate
1978	36,581	12	15.8	8.3
1979	38,916	11	15	7.7

Preliminary data for 1980 reflects a further decrease of infant mortality to 10.3/1,000 births.

The infant mortality among blacks however remains extremely high, 20.6 with Wyandotte County's rate of 26.2 even higher than the nation's.

The number of births to young mothers under eighteen is decreasing in Kansas from 7.2% in 1975 to 4% in 1979. Of the births to mothers under 20 years of age 36.6% were out-of-wedlock. The number of elective home births are small but increased from 147 in 1978 to 180 in 1979.

2. Family Planning

Family planning clinics are now located in 63 counties and during 1980 served approximately 41,000 persons, 32% being nineteen years of age or younger. Barriers to service for minors exist in Sedgwick and Johnson County as parental consent is required. During the year natural family planning activities expanded with a grant to St. Francis Hospital in Wichita with services in Wichita, Topeka, and Hays.

3. Pregnancy Care

A. Maternity and Infant Care

Approximately 78% of Kansas women receive early pregnancy health care, however, only 50% of the very young and low income mothers receive appropriate care. Nine counties have addressed this problem with special maternity and infant care projects for

for adolescents. Two new projects were authorized by the 1980 Legislature at the request of the Children and Youth Advisory Committee. These programs are located in Shawnee, Sedgwick, Wyandotte, Johnson, Saline, Geary, Riley, Leavenworth, and Reno. For the year ending July 1, 1980, 840 pregnant adolescents and 451 infants received these comprehensive services. Only 2.5% of the M & I infants required intensive infant care as compared to the national average of 7% of infants born to young mothers.

B. Kansas Natality Survey

A sample (1,320) of the 38,000 women who gave birth in 1979 were surveyed to assess the prevalence of health risk factors in pregnancies. Results: 32% smoked, 56% drank alcohol, 25% were non-prescription drug users. The largest percentages of smokers and drug users were black, unmarried, with less education. The reverse was true of alcohol consumers who were most often white, married, with more than high school education, and earlier in obtaining prenatal care (83%, 1st trimester care as compared to 78% for general population).

C. Prenatal Education Survey

Content and availability of prenatal education was studied in a survey of 186 educators. Classes were identified in 82 of 105 counties, eighteen were early pregnancy classes.

D. State Perinatal Care Program

During 1980 there were 450 sick newborns transferred for treatment to the Level III centers at KUMC, Kansas City, and Wesley Hospital in Wichita. Also there were 126 high risk pregnant women who were transported to Wesley Hospital for delivery. Increasingly, the Level II centers throughout the state are providing consultation and referral sources from primary care hospitals. Four quarterly meetings for perinatal medical providers were sponsored during the year at Wichita, Parsons, Junction City, and Shawnee Mission, with 331 professionals participating.

4. WIC Program

During 1980 the monthly caseload for the supplemental food program was 3,110 pregnant or lactating women, 3,778 infants, and 8,778 preschool children (July 1, 1979). There are 13 local agencies operating programs in 28 counties.

The state's computerized food voucher system has simplified the administration by local programs. This has been a popular program which has led to better utilization of preventive health services for high risk mothers and children. The major problem is inadequate coverage of the state and in some existing projects - waiting lists.

5. Family Centered Maternity Care

Consultation has been provided to approximately 45 hospitals on the subject of family centered maternity care including the development of "birthing" rooms. At present 36 hospitals have approved family centered care plans with 10 hospitals including birthing rooms in the plan.

Kansas is the first state to develop regulations for licensing Maternity Centers, facilities for the delivery of low risk women in a more homelike environment. One center in Topeka was approved during 1980 for this care.

6. Pierre the Pelican

The Pierre the Pelican Prenatal Newsletter Series is mailed out to expectant parents and parents of babies up to one year of age upon request. The objective of the newsletters is to educate expectant and new parents to have realistic expectations about pregnancy and the normal development of infants. The series is extremely popular with parents. Present total enrollment for the program is 3,287 prenatal and 8,986 postnatal. Mental Health Centers and Cooperative Extension Offices are mailing the newsletters in 22 counties with the Bureau handling the remainder.

7. Healthy Start - Home Visitor Program

The Healthy Start - Home Visitor Program for families with newsborns provides primary prevention services and reduces the incidence of serious abuse and neglect of infants and young children. During 1980, there were 5,546 births in the project area and trained lay home visitors visited 2,865 mothers in the hospital and made home visits to 3,139 families. Referrals for preventive health services increased throughout the area. Training programs for lay visitors, using staff consultants from the Department of Health and Environment and Social and Rehabilitation Services, were held quarterly.

8. Genetic Disease Programs

A. Phenylketonuria (PKU) and Hypothyroidism

There were 31,570 newborn screening tests for PKU and hypothyroidism performed by the Department of Health and Environment laboratory.

Hypothyroidism: 512 infants were retested because the initial test was positive. There were 9 infants identified as having primary hypothyroidism and are under treatment to promote normal development.

Phenylketonuria: 2 infants were retested because of presumptive positive tests. One child is still under observation for Hyperphenylalaninemia. This was an unusual year in which no cases of PKU were identified.

Clinic services for these conditions, including dietary mangement and genetic counseling, were provided at KUMC and UKMS-Wichita for 92 persons. The dietary treatment product was provided to 26 children with PKU.

B. Sickle Cell Anemia

The laboratory which performs sickle cell screening under a contract with the Department screened 3,551 individuals during 1980. Of this number 260 tests were positive for the sickle cell trait. These individuals received genetic counseling. Education programs were carried out in several schools using films, pamphlets, and speakers provided by the Department. Medical and hospital care are provided by the Department for persons with sickle cell disease.

C. Cystic Fibrosis

This program provided necessary drugs and inhalation equipment for 226 individuals during 1980. Diagnostic and control clinic services are offered at two locations (KUMC and St. Joseph Medical Center in Wichita) for children with cystic fibrosis, a life threatening genetic disease. The objectives of the program are to prevent hospitalization and increased dependency with home services to families with this disease. Genetic counseling is a component service of the program. Fifty children were approved for medical and hospital care by the Crippled Children's Program.

D. Genetic Counseling

The Genetic Counseling Center of Topeka and clinics at KUMC and UKMS-Wichita receive funds from the Bureau to provide genetic testing and counseling to Kansas families. This includes premarital and prenatal services as well as services to families who have experienced the birth of a child with a birth defect.

10. Licensing of Child Care Facilities

The 1980 Legislature revised the Child Care Licensing Act to permit registration of day care homes caring for six or fewer children, effective July, 1980. By January, 1981, 782 persons had applied for registration through the use of a self-evaluation checklist. Also by the end of the year there were 2,479 family day care homes licensed or license pending. The revised law has resulted in extending

protection to additional children with approximately 25,000 in registered and licensed family home care. Also, there are 869 child care centers, and 1,850 foster family homes under the licensing program. Through licensing standards efforts are made to promote optimal care outside of the child's home and prevent health problems and abusive or neglectful situations. The need for safe day care will continue to grow with the increasing numbers of working women. Foster family home regulations were revised during the year with the legislative review committee rejecting the prohibition of spanking. This past year there have been several outbreaks of infectious diseases among infants in group day care centers. A number of child care facilities have had to be closed this year because of abuse or neglect of children in care.

11. Special Projects

A. Children and Youth Projects

The Kansas City and Topeka comprehensive medical care projects for low income children 0-21 are providing services to 8,000 children. The major problems are caused by yearly inflation with fixed grant awards over the past several years.

B. Dental Projects

The two dental programs at KUMC and Wichita-Sedgwick County Health Department are providing comprehensive dental services for 6,000 children.

C. Migrant Health

The Western Kansas Migrant Program operates in seven western counties and due to budget limitations most of the health services are preventive and for pregnant women and children. An associated WIC program places strong emphasis on nutrition.

12. School and Preschool Health Programs

A. School Health

During 1980 a concerted effort was placed upon promotion of child health assessments for school enterers as requested by the 1980 Legislature. A revised child health assessment form provided by Department of Health and Environment has been well received and is in use in most school districts. During 1980 a school health services survey was made by the Department of Health and Environment. Initial tabulations reveal that 77% of the school districts have responded, which represents 89% of the school population, with 116 districts reporting that health assessments were required for school entry. Additionally most schools encourage health assessments upon school entrance. Of the districts reporting, 76% of children entering school for the first time submit reports of child health assessments. School health promotion efforts were facilitated

during 1980 with the award by CDC of risk reduction grants to schools in Lawrence and Topeka with health education consultation provided by the Department of Health and Environment.

B. Immunizations

The Department of Health and Environment conducts a regular surveillance program on the status of immunizations in day care programs, Kindergarten and schools. Day Care Providers are encouraged to review and update immunizations on each child enrolled and provide the Department with a report. The immunization level has consistently remained above 90%. The Kindergarten level has also been above 90% for the past three years.

C. Hearing Conservation

In addition to the regularly scheduled training programs for personnel doing hearing screening on children, this Department worked closely with the Department of Education on the Child Find Program. The purpose of the program was to identify and assess preschool children with handicapping conditions. Training programs and continuing education courses were held for both lay and professional people to increase their knowledge. Screening programs were held to assess these children and identify the types of handicaps. 1,386 children 0-5 years of age had hearing screening with 746 being identified in need of follow-up.

13. Crippled Children's Program

The thrust of Kansas Crippled Children's Program in calendar year 1980 has included increased availability of diagnosis and treatment services and increased interagency involvement. There are approximately 5,000 children in active treatment through KsCCP services. A branch office of KsCCP in Wichita became fully operational and serves the population of children receiving their health care in the Wichita area. There have been regional staff contracted in Wichita, Kansas City, and Parsons to serve the child population receiving KsCCP services with focus on the children receiving SSI/Disabled Children's Program Unit service.

In association with the Parsons University Affiliated Facility and the Parsons State Hospital and Training Center, KsCCP sponsors a clinic which meets every other month to provide diagnosis and treatment. The health care disciplines involved in tis clinic are nursing, nutrition, orthopedics, orthotics, pediatrics, physical therapy, physiatry, and social work. The number of children seen at each clinic is between 45-65 and are referred by school personnel, public health personnel, and private physicians. The pediatric cardiologist from the University of Kansas Medical Center has conducted outreach cardiology diagnosis and treatment clinics in Hays and Manhattan. The number of children seen in each clinic is between 6-12 and are referred primarily by the local medical community. Six otology clinics funded by KsCCP and

conducted by staff of the Bureau of Maternal and Child Health were held across the state. There were between 40-45 children seen at each clinic site with referrals from school personnel, public health personnel, and private physicians.

Increased involvement with the Department of Social and Rehabilitation Services has resulted in a more active role to identify and refer potential recipients for Title XIX services and the ability of KsCCP staff to prior authorize Medicaid payment of a limited number of durable medical equipment items.

The Department of Education, Special Education, and KsCCP jointly planned two pilot projects at Garden City and Parsons using a multi-discipline team to review findings, examine children, arbitrate on certain issues and make recommendations for the educational plans of children with complex problems. The multi-discipline team includes health care and educational disciplines. The discipline components of the team may vary with the needs of the children being evaluated. Local medical and educational personnel are involved in selection of the team members and participate in the evaluation. The first Special Child Clinic will be held in January in Garden City. Referrals will be made by school personnel, public health department personnel, social service agency personnel, and the local medical community.

The calendar year 1981 focus of KsCCP will be to continue to increase availability for diagnosis and treatment and to increase interagency involvement. The activities discussed will be continued as planned in addition to the development of a clinic in the Northwest similar to the ongoing Parsons clinic, is being planned.

STATEMENT

BY

VERNON K. SMITH, PH.D.

DIRECTOR

MEDICAID POLICY AND PROVIDER SERVICES

MEDICAL SERVICES ADMINISTRATION

MICHIGAN DEPARTMENT OF SOCIAL SERVICES

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

WEDNESDAY, APRIL 1, 1981

I. Introduction

Mr. Chairman and Members of the Committee: I am Vernon K. Smith, Ph.D., Director, Medicaid Policy and Provider Services, for the Michigan Medicaid agency (the Michigan Department of Social Services, Medical Services Administration). I was the Budget Director for the Michigan Department of Social Services.

I am also Chairman of the national Technical Advisory Group (TAG), composed of state Medicaid Directors and state Program Managers for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which advises the Health Care Financing Administration (HCFA) on all aspects of the EPSDT program. The ESPDT Advisory Group has provided an excellent example of how the state-federal partnership can work toward:

. effective administration
. improved performance
. simplification of procedures
. regulatory change

for the preventive child health component of the Medicaid program.

II. Effects of a Federal Funding Cap on Medicaid

I am pleased to appear before the Committee today to discuss some of the major impacts of a federal funding cap on Medicaid. I would add my voice to those from many other states who have supported the position of the National Governors' Association (NGA) regarding the proposed five percent Medicaid cap. Governor Hunt of North Carolina, Chairman of the Committee on Human Resources of the National Governors' Association, has succinctly summarized the NGA position on a Medicaid cap:

". . . it is not acceptable."

Of the significant concerns that states have regarding the proposed cap, those relating to child health are among the most important:

INEVITABLY, THE PROPOSED CAP WILL FORCE STATES TO PLACE LESS PRIORITY ON CHILD HEALTH AND PREVENTIVE CHILD HEALTH PROGRAMS.

INEVITABLY, THEREFORE, THE PROPOSED CAP WILL ADVERSELY AFFECT THE CURRENT AND FUTURE HEALTH STATUS OF CHILDREN IN LOW-INCOME, MEDICAID-ELIGIBLE FAMILIES.

Allow me to illustrate how this will occur, using the State of Michigan as an example.

Michigan was among the first of the states to fully implement the EPSDT program in 1972-73. Our approach has been to fully integrate EPSDT into the mainstream of the Medicaid program and into the range of other preventive child health programs, such as the Title V Crippled Childrens program. The Medicaid agency contracts with the Michigan Department of Public Health for the screening aspect of EPSDT. The Department of Public Health, which administers public clinics and the Crippled Childrens program, contracts with the Department of Social Services, within which the Medicaid agency is the fiscal intermediary for the processing of Medicaid claims, to be the fiscal intermediary for Crippled Childrens claims. In this manner, there is coordination at the state level among public health programs such as Crippled Children, EPSDT and the entire Medicaid program for scope of coverage, determination of eligibility, source of funding, common data base management, unduplicated referrals, and processing of claims. Without this coordination and focus, low income children in many instances would be left on their own for preventive health treatment.

In Michigan, fiscal year 1979-80 expenditures for the full Medicaid program totaled just over $1 billion. Of this amount:

. EPSDT Screening (under contract with Department of Public Health) . . . . $ 8 million

. Medicaid payments for EPSDT eligibles for physicians, dentists, other outpatient and inpatient diagnosis and treatment services . . . . $232 million

CLEARLY, THE EPSDT PROGRAM ACHIEVES ITS PURPOSE OF PREVENTIVE HEALTH CARE BY PROVIDING A FOCUS AND AN ELEVATED EMPHASIS ON PREVENTIVE CARE WITHIN THE MAINSTREAM OF THE MEDICAID PROGRAM ITSELF.

From a state perspective, the success of an EPSDT program can be measured by the extent to which it is fully integrated with Medicaid. Indeed,

EPSDT should be viewed less as a distinct program than as the mechanism within Medicaid through which is achieved the entitlement promised by Title XIX for access to preventive and acute health care for Medicaid-eligible children.

Now, with this background, it can be shown with certainty that a cap will adversely impact the avail'bility of preventive and continuing care for Medicaid children, because this has already occurred in Michigan.

The fiscal shortfalls caused by economic decline and unemployment in the State of Michigan in the last three years have already forced Michigan to make hard decisions to reduce program costs. The lack of state matching funds has served as a state cap, and a powerful incentive to cut the program. The depth of the fiscal shortfall has been so severe that the Medicaid program has been forced to move well beyond reasonable "cost containment" policies into arbitrary "cost reduction" actions in order to contain spending within available resources.

The cost-cutting and cost avoidance measures undertaken in Michigan have an annual value of $238 million. (See Attachment A for a listing.) While every effort has been made to minimize the impact on recipients, that goal is simply not achievable when program savings of this magnitude are necessary. Examples of Michigan's actions which affect children include:

- Reduce the number of EPSDT screenings.

- Reduce reimbursement levels for physicians, dentists and pharmacists. Reduced reimbursement, together with other actions, has adversely affected provider participation in Medicaid, making it more difficult for child and adult recipients to locate and maintain continuing medical care, and increasing the likelihood that a recipient may use a hospital emergency room when a physician visit was more appropriate.

- Elimination of certain drugs such as Valium from Medicaid coverage. This has, in some cases, created financial hardship or added to health risk, particulary among children whose spasticity, cerebral palsy or seizure control is uniquely achieved through treatment involving one of the drugs eliminated from coverage.

If it were possible for Michigan to live with the proposed cap, it would only be because:

. Cost reduction measures initiated over the past two years are just now bearing fruit.

. The state has responded, as a co-equal funding partner with the federal government, to its own interest that funds be expended responsibly, effectively and efficiently.

. Policies are adopted which adversely affect adults and children who rely on Medicaid for both preventive and ongoing health care.

In Michigan, we recognize that cost containment policies and program cuts are forced upon us by the state's current fiscal emergency and by the statutory formula for determining a state's Federal Medicaid Assistance Percentage (FMAP).*

A major concern in Michigan is that these policies and program cuts may turn out to be short-sighted. Under current regulatory constraints, a state which wishes to cut Medicaid costs has a limited array of options, most notably including:

. reducing provider fees
. reducing optional benefit packages
. reducing eligibility
. imposing utilization controls

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*The statutory FMAP formula is completely unresponsive to the economic situation of a state such as Michigan, which last year had the highest unemployment rate in the United States, and an actual reduction in state revenues. These circumstances have severely strained Michigan's ability to finance its share of Medicaid expenditures. Yet, the Federal Medical Assistance Percentage for Michigan is the minimum allowed under current statute, 50 percent.

This formula requires amendment. We would suggest, for example, a simple "unemployment trigger," with a state's FMAP increased in relationship to each percentage point a state's unemployment rate exceeded the national average. Michigan is prepared to discuss the specifics of such an amendment with the Committee and staff.

This amended formula would provide modest, equitable, timely and appropriate relief for states which experience extreme economic downturns and consequent inability to finance both state programs and state-federal programs such as Medicaid.

Part of Michigan's concern with the proposed cap is that its historical base for allocating funds to states will perpetuate the inequities of the existing FMAP formula, and fail to offer credit to a state for cost containment and cost reduction actions already enacted and therefore included in the base.

The ultimate result of cutting back on preventive, ambulatory services through any of these options may well be to increase costs of the Medicaid program. Increased costs may occur because of:

- Increased cost of future health care due to reduced preventive measures currently delivered through EPSDT;
- Increased use of high-cost institutional services, such as inpatient hospitalization or nursing home care; or,
- Increased use of emergency rooms where access to mainstream, primary care is restricted.

Available evidence suggests these results will in fact occur. A recent study in North Dakota showed that children receiving EPSDT services used up to 39 percent fewer inpatient services, and that per capita expenditures for screened persons were 36 to 44 percent lower than for unscreened persons. (See Attachment B for abstract.)

Further, it is likely that the proposed cap will force states into arbitrary reductions and exclusions which will fall more heavily on children than on adults. This result will occur because children are less likely to utilize hospital and nursing home care, which together account for 80 percent of Medicaid expenditures nationally. Under present statutory requirements, costs for both hospitals and nursing homes are likely to increase at a pace exceeding the increase in a Medicaid cap -- thus, further increasing the share of total expenditures allocated to these areas.

Nationally, children comprise 47 percent of Medicaid eligibles, but account for only 17 percent of Medicaid expenditures. Unless there is relief from the "reasonable cost" principle of reimbursement for institutional providers, it is inevitable that there be not just a reduced proportion, but a reduction in absolute dollars, in the allocation of Medicaid funds for children and preventive child health care. This result must indeed be regarded as shortsighted.

In summary, key consequences of the proposed Medicaid cap upon preventive and child health programs include:

- Reduced spending for preventive health services, especially for Medicaid-eligible children.

- Reduced health screening of Medicaid-eligible children through EPSDT.
- Reduced access to primary, continuing medical care for Medicaid-eligible children.
- State initiatives to eliminate coverage for certain optional services.
- Possible increases in Medicaid costs due to utilization of institutional providers of health care.
- Long- and short-term health consequences for children whose health care is provided through Medicaid.

III. Recommendations

From the above discussions of the consequences upon child health, there are several recommendations:

A. Do not cap federal Medicaid funding.

To do so will fundamentally alter the financing structure for Medicaid to the detriment of children and adult Medicaid beneficiaries.

B. Remove constraints which impede the ability of states to rationally and efficiently manage the EPSDT component of the Medicaid program.

1. Repeal Section 403 (g) of the Social Security Act. States do not need the threat of fiscal penalties to achieve an effective program. The repeal of this Section should not be interpreted in any way as a lessening of emphasis or priority on child health or preventive health programs.

2. In this regard, the national EPSDT Advisory Group has been working closely with the Health Care Financing Administration to strengthen EPSDT while removing counter-productive procedural requirements and other regulatory restraints related to the penalty statute and associated regulations.

C. Provide states flexibility to manage the Medicaid program, including EPSDT, in a prudent manner.

It must be remembered that for more than one-fourth of the states, the <u>state</u> medical assistance percentage is the same as the <u>federal</u> medical

assistance percentage.

Additionally, in many states (including Michigan), Medicaid is the largest single program in the entire state budget.

In this context, a state's incentives for cost containment and prudent program management reflect its own fiscal interest, and the federal government reaps the benefits equally with the state when cost savings are achieved.

However, current federal law and regulation constrain states from adopting policies which would serve the public interest and reduce overall state and federal costs. The specifics have been outlined by the National Governors' Association and are listed for emphasis below:

		Law (SSA)	Reg (42 CFR)
1.	Reasonable Cost	1902(a)(13)(D)	447.261-62
2.	Reasonable Charge	1902(a)(30)	447.341
3.	Prepaid Health Plans	1902(a)(4)	431.565
4.	Utilization Controls by Diagnosis	1902(a)(10)	440.230
5.	Client Cost Sharing	1902(a)(14)	447.51-59
6.	Freedom of Choice	1902(a)(23)	431.51
7.	PSRO as Determiner of MA Payments	1158(c)	
8.	Maintenance of Effort	1618	
9.	Federal Medical Assistance Percentage	1905(b)	433.10
10.	Eligibility Conditions (Buy-in)	1837(e)	435.501(c)
11.	Equality of Benefits	1902(a)(9)	440.240
12.	EPSDT Penalty	403(g)	441.70-71

The ultimate effect of adopting these recommendations will be:

- to enhance the priority of preventive and ongoing health care for children;
- to allow states to fund an equitable share of program costs;
- to allow states the flexibility and authority needed to manage the Medicaid program, including the child health component, in a cost-effective, efficient manner.

In summary, the proposed cap on federal Medicaid expenditures will force states, Michigan in particular, to reduce Medicaid expenditures for child preventive care through EPSDT. This reduction in PREVENTIVE services will no doubt increase future Medicaid costs because of health problems left untreated or undetected in the child population.

Let us remember that adage "an ounce of prevention is worth a pound of cure" is nowhere more applicable, nor more critical, than in the case of the health of a child.

VKS:tj
03/30/81

Attachments

ATTACHMENT A

APPENDIX 2

SAVINGS TO MICHIGAN MEDICAID PROGRAM, FY 1980-81

Medicaid Cost Containment
(In millions of dollars)

Policy	Implementation Date	Annual Savings	
Third-party liability	FY 77-78		$18.0
		FY 78-79	27.3
		FY 79-80	39.5
		FY 80-81*	46.0
Second surgical opinion program	FY 79-80		$ 2.0
		FY 80-81*	4.0
Volume purchase of eyeglasses	FY 79-80		$ .25
		FY 80-81*	.50
Generalist vs. specialist fees	FY 78-79		$ 1.0
		FY 79-80	2.0
		FY 80-81*	2.0
Routine testing	FY 79-80		$ .50
		FY 80-81*	.50
Outpatient hospital laboratory	FY 79-80		$ 1.0
		FY 80-81*	2.1
Automated testing; laboratory	FY 77-78		$ 1.3
		FY 78-79	1.3
		FY 79-80	1.3
		FY 80-81*	1.3
Pharmacy co-pay	FY 80-81		$ 3.0

Medicaid Cost Containment, continued

Policy	Implementation Date	Annual Savings	
Recipient monitoring	FY 78-79 Pilot		
	FY 79-80 Expanded		$ .50
		FY 80-81*	1.0
HMO	FY 74-75	FY 80-81*	
		CHSD	$ 2.2
		MHMOP	1.3
		THCD	.92
		FHCP	.05
		GHS	.03
		HAP	.008
Fraud and abuse	FY 76-79	FY 80-81*	$ 4.0
Alternatives to institutional and nursing home care		FY 80-81*	$150.0
Prospective reimbursement for long-term care facilities	FY 1978-79	FY 80-81*	$15.0
Prospective reimbursement for hospitals	FY 1979-80	FY 80-81*	$ 5.0
Inpatient/ambulatory fee differential	FY 1979-80	FY 80-81*	$ 1.0
TOTAL FY 80-81 SAVINGS			$238.2

*Projected.

APPENDIX 3

MICHIGAN MEDICAID COST CONTAINMENT MEASURES

Hospitals

1. "Prudent buyer" concept for outpatient laboratory services

The concept of "prudent buyer" means that given equal or comparable quality standards, Medicaid reimbursement for a service should be at the lowest charge level at which the service is widely and consistently available. This concept was applied to outpatient laboratory services (federal regulations prohibited its application to inpatient services) by establishing a policy that all services included in the outpatient hospital laboratory cost center will be reimbursed at Medicaid's prevailing fee-for-service or the hospital's usual and customary charge, whichever is less.

The impact of this policy was felt primarily by outpatient hospital centers which previously had been reimbursed under the cost settlement process; under that reimbursement approach, outpatient hospital settings received a higher reimbursement rate than physicians and independent labs.

Cost Analysis:

--Implementation 1979-80.
--$2.1 million saved in FY 80-81 under this policy (32% reduction in OPH lab expenditures);
$1 million saved in FY 79-80.

2. Routine hospital laboratory and radiology testing policy

Many unnecessary and costly laboratory and radiology tests are performed in hospitals because of existing general hospital policy or because of an attending physician's standing orders. Such routine administration attests to the fact that consideration has not been given to the individual patient's condition or diagnosis. In order to avoid unnecessary testing, the Medicaid program adopted a policy that, on elective inpatient hopsital admissions, testing not specifically ordered by a physician not be reimbursed. Admission tests are defined as all those tests which are directly related to an admission and are performed within the first 48 hours of admission.

Cost Analysis:

--Implementation FY 1979-80.
--Michigan Medicaid saves $.5 million annually through this program.

3. Mandatory Surgical Second Opinion Program

The Surgical Second Opinion Program (SSOP) is designed to reduce surgical utilization by reducing the number of initial recommendations for surgery (referred to as the sentinel effect) and by reducing the number of surgeries which occur after the second opinion. SSOP results not only in cost savings, but has the additional benefit of protecting Medicaid recipients from unnecessary surgery.

A Congressional Committee Report estimated that between 1.9 million and 2.4 million unnecessary surgeries were being performed in this country, resulting in an unnecessary cost of between $3.6 and $4.5 billion and causing over 10,000 unnecessary deaths due to complications. Requiring a second opinion for those non-emergency cases of elective surgery which are most prone to abuse should decrease the amount of surgery performed under Medicaid by up to 20%. The decrease in surgery results from two sources: a 13% non-confirmation rate (the second surgeon says that surgery is not needed), and a "sentinel effect" decreasing the amount of unneeded surgery ordered because the doctor knows that he or she will be reviewed.

Under Michigan's program, eight surgical procedures are covered (cholecystectomy, dilatation and curettage, hemorrhoidectomy, hernia repair, hysterectomy, meniscectomy, tonsillectomy and/or adenoidectomy, and urinary system endoscopy). In order for a physician to be reimbursed for one of the covered procedures, the recipient must have received a second opinon.

Cost Analysis:

--Implementation FY 79-80.
--In FY 1980, the program saved $2 million while operational only in the Greater Detroit metropolitan area. The program is now fully operational statewide and is expected to save $4 million annually.

Laboratories

4. Automated testing policy

An investigation of laboratory billings showed that lab providers were performing automated tests and billing them as manual tests in order to receive higher manual rates, and that physicians were performing lab tests manually in their offices when it would be cheaper and more accurate to send the tests to an independent lab with the capability to run automated tests. In order to save costs, the Medicaid program revised its payment mechanism for automated lab tests by specifying 14 tests which are commonly available on automated equipment and specifying that such tests will be paid only at automated rates.

Cost Analysis:

--Implementation FY 77-78
--Prior to implementation, an average of $3.31 was paid per occurrence on the specified tests. After implementation, the

average payment per individual test was $1.43. Michigan Medicaid saves $1.8 million annually with this project.

Other Measures

5. Recipient monitoring project

The recipient monitoring project was designed to identify recipients who are misutilizing Medicaid services. Major areas subject to abuse include office visits, addictive or psychotropic drugs and emergency room visits. Once the recipients are identified (by an edit on the computer program), they are placed in a program designed to reduce use to appropriate levels. (Note: This program has also resulted in the identification of abusive providers who are dealt with through Michigan's new provider fraud law.) A combination of counseling, voluntary "contracts" to reduce usage, prior authorization, and "lock-in" to a single provider are techniques employed to reduce utilization.

Cost Analysis

—Implementation: FY 78-79 pilot; FY 79-80 expanded.
—Program saves $1 million annually.

6. Volume purchase of eyeglasses

In order to enhance the quality of eyewear available to Medicaid recipients and to pursue cost savings, the Michigan Medicaid program implemented a volume purchase of eyeglasses. This program eliminates the price markups between manufacturers and wholesalers, and between wholesalers and retailers. Prior to the establishment of the program, a provider procured eyewear from any source which he or she desired after receiving prior authorization to furnish the glasses. Lenses were billed at the provider's usual and customary charge. For frames and fitting services, the provider billed his or her usual and customary charge of the acquisition cost of the frames plus $7.00, whichever was less (the amount not to exceed $17.00).

Under the program, the state contracted with Bausch & Lomb for a variety of frames and spectacle lenses. Subsequent to receiving prior authorization from the program, providers are reimbursed only for dispensing the eyeglasses. The program is billed directly by Bausch & Lomb for the materials. Medicaid recipients may choose any optometrist or other eye professional for exams and fittings. These providers, however, must order eyewear from Bausch & Lomb.

Cost Analysis:

—Implementation FY 1979-80.
—The program has resulted in a savings of $500,000 in materials (30% of the program costs).

7. Health Maintenance Organization (HMO) enrollment

Allowing the choice of HMO enrollment for Medicaid recipients results in both cost savings to the state's program, as well as furthering the recipient's freedom of choice among providers and increasing access to mainstream health care enjoyed by other Michigan health care consumers. Michigan has more Medicaid recipients enrolled in HMOs than any other state in the Union, with a 6% enrollment statewide and a 20% enrollment in the Greater Detroit metropolitan area. HMOs provide an agreed-upon set of health-care services (all Medicaid services except long-term care and dental) to voluntarily enrolled recipients for a fixed periodic rate which is prepaid on a monthly basis on behalf of each enrolled recipient. Currently, there are five HMOs serving six Michigan counties which have contracted with the Medicaid program.

Cost Analysis:

—Implementation FY 1974-75.
—The HMO program saves 10% each year on each Medicaid recipient enrolled. Total savings at current enrollment levels are $4.5 million annually.

Expansion of this program is inhibited by federal regulations setting arbitrary limits on the number of Medicaid recipients allowed in each HMO (as detailed in Appendix 1 on regulations) and the scarcity of HMOs. It will be further hampered by the Administration proposal to end funding to establish new HMOs.

8. Alternatives to long-term care

For the past five years, Michigan has committed itself to treating patients in the least restrictive setting possible, while still maintaining adequate care. This policy is both cost-effective and offers the patient the best chances for recovery concomitant with meeting the desires of most persons to live as independently as possible.

Michigan provides Adult Home Help Services to allow patients to stay at home. Several gradations of care are available in foster care settings. No new Medicaid-paid nursing home beds have been added since 1975. As a result, Michigan spends just over half the national average on nursing homes.

This success story required Michigan to commit money up-front to begin this program. (Under the proposed Medicaid cap, such funding would not be available.) This effort has required the commitment of a large part of Michigan's Title XX Social Services monies, along with some Medicaid monies for personal care and home help services. Michigan has had to hire staff to seek out and license private Adult Foster Care homes and to screen and place clients in the homes. Even with these expenses, Michigan saves tremendously with this program.

If the maintenance-of-effort regulation in the SSI grant program were relaxed as detailed in Appendix 1, further expansion and additional savings would be possible.

Cost Analysis:

—Implementation FY 1975-76.
—Net savings from the deinstitutionalization program is $150 million annually, and grows each year. Michigan pays 33 cents of every Medicaid dollar on long-term care compared with the national average of 45 cents on the dollar.

9. Third-party liability

Medicaid is mandated to be the payer of last resort for medical services. Clients with other insurance coverage which may cover medical expenses should have their bills submitted to the private insurer first. Many Medicaid providers, unaware that private coverage exists, bill Medicaid first.

With the aid of seed funding for programming and staff, Michigan Medicaid has developed a computer system which keeps updated files on clients' insurance coverage. Doctor and hospital bills are screened before payment; bills which should go to other insurers first are refused. In the event that a bill is paid where other insurance exists, the program attempts to collect the monies spent from the private insurer and has instituted litigation to recover funds from other payers.

Cost Analysis:

—Implementation FY 1977-78.
—Savings for this program average $10 for every $1 spent. Savings in FY 1981 are expected to be $46 million (FY 78, $18.0 million; FY 79, $27.3 million; and FY 80, $39.5 million).

10. Generalist versus specialist fees

The availability of general practitioners who accept Medicaid clients is a fundamental factor in preventing over-utilization of specialists and emergency rooms. Michigan Medicaid pays the same rate for the same service, irrespective of whether it was provided by a generalist or a specialist. This policy is designed to discourage higher-priced specialists from doing routine work and to encourage general practitioners to participate in the Medicaid program.

Cost Analysis:

—Implementation FY 1978-79.
—$2 million is saved annually through this program.

11. Pharmacy co-payments

Recently Michigan instituted a Medicaid recipient co-payment requirement for certain pharmaceutical drugs. If a drug is prescribed for which a cheaper generic equivalent exists and if the generic drug is utilized to fill the prescription, then no client co-payment is required. If the druggist fills the prescription with the expensive "name brand," he or she must charge the recipient a 50-cent co-payment and that amount is deducted from the dispensing fee paid by the Medicaid program. Similarly, if the client insists on the higher-cost drug, he or she must pay the 50-cent co-payment.

This program is designed to educate the client to availability of generic drugs. Druggists, generally desirous of avoiding collection of co-payments, find it to their advantage to use and explain the use of generic drugs.

Cost Analysis:

—Implementation FY 1980-81.
—This program is projected to save $3 million annually.

12. Control of provider fraud and abuse

Medicaid providers cost the Medicaid program more in fraud and abuse than do program recipients. Also, provider fraud and abuse has been more difficult to prove in court (due to legal loopholes in the Medicaid program). Finally, remedies to deal with abusive providers have been limited.

This is an area in which Michigan has again shown unique initiative in addition to effective response to federal requirements. Fraud and abuse cost the public a lot of money, an estimated $6 billion annually (National Health Insurance Reporter, October 31, 1980, quoting Califano).

The State of Michigan both responded to federal initiatives and devised its own to deal with this pervasive, costly problem. Michigan's Medicaid Management Information System gained a fully certified Surveillance and Utilization Review Subsystem that is one of the most sophisticated tools available to any health-care third-party payer anywhere.

The Michigan Legislature enacted the Medicaid False Claims Act, which has assisted the work of the Medicaid Fraud Control unit. From September 30, 1978 to December 31, 1981, this component of the Attorney General's Economic Crime Division expended a total of $1.3 million in state and federal funds with which it saved the program about $10 million in costs avoided by elimination of providers' fraud and with which it actually recovered $591,000 in restitution.

Most recently, Michigan passed a tough provider-fraud law designed to close the more frequently used legal loopholes of fraudulent providers. This bill was the result of several years of study and is quite complex. The major provisions follow:

(a) Providers are required to be responsible for their own billings. (It will no longer be sufficient to blame consistent overbillings or the billing service.)

(b) Providers must personally sign their own reimbursement checks. (Previously, doctors would not sign their own checks and would assert in court that they never received the overpayment.)

(c) Providers shall not bill Medicaid more than they bill any other third-party payer or individual.

(d) Providers may be suspended from Medicaid; "limited sanctions" may be applied whereby one area of practice, say, ordering lab work, would come under continued monitoring and control (i.e., limited sanctions used to pinpoint the problem); Medicaid's ability to recover overpayments is increased by withholding a portion of current payments. Furthermore, the increased range of sanctions should increase the number of cases brought to a successful conclusion with fewer court appeals ensuing.

Cost Analysis:

—Implementation FY 1978-79.
--The provider-fraud bill is projected to save $5 million the first year and progressively more in later years. Of the initial savings, about $1.0 to $1.5 million will result from establishing a statutory basis for protection of activities which the Department has already undertaken; $3.0 to $4.0 million from direct avoidance of costs, including savings from modification in abusive providers' behavior; and an estimated $1.0 million from deterrence, an annual savings which is expected to rise over time.

13. Prospective reimbursement for long-term care facilities

Michigan several years ago instituted a wholly prospective reimbursement system for long-term care facilities. Historically, under a cost reimbursement system, the rate of increase in the cost of long-term care facilities approximated the inflation rate. Since the introduction of prospective reimbursement (1978 in Michigan) the rate of increase for long-term care facilities has risen 5% less than the underlying inflation rate.

Cost Analysis:

—Michigan is spending $15 million less each year for long-term care than it would have spent under the previous system as a result of the prospective reimbursement system.

14. Prospective reimbursement for hospitals

In 1980 Michigan introduced a prospective reimbursement system for inpatient hospital care similar in concept to our program for long-term care.

The reimbursement rate system was negotiated with the hospital association at the end of the year to insure that reasonable cost is paid.

Cost Analysis:

—This program is expected to save $5 million this year.

15. Inpatient/ambulatory fee differential

Over the last two years, Michigan has created a fee differential for services which could be rendered in an ambulatory setting as opposed to an inpatient hosital setting. If the service can be rendered in an outpatient setting or in a doctor's office, Michigan wants to encourage that the services be performed in the less expensive setting. Therefore, Michigan Medicaid will pay more to the doctor if he or she orders that these services be rendered in the ambulatory setting.

Cost Analysis:

--Cost savings for this program are estimated at $1 million annually.

ATTACHMENT B

ABSTRACT June 1980

DOCUMENT: Cost Impact Study of the North Dakota EPSDT Program, Community Health Foundation, September 1977

NUMERICAL FILING SEQUENCE: 50

NUMBER OF VOLUMES : 1 of 1

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STATES OR AREAS COVERED : North Dakota

TIME PERIOD : 1977

PURPOSE:

To assess the impact of the EPSDT program on Medicaid expenditures.

KEY FEATURES:

- o Examines impact of EPSDT on utilization of medical services.
- o Examines the extent to which EPSDT modified total Medicaid expenditures for child health in one community in North Dakota in one year.

PRINCIPAL FINDINGS:

- o There are differences in the utilization of medical services between Medicaid recipients who participate in EPSDT and those who do not participate. Screened persons used 21 to 39 percent fewer inpatient hospital services. Screened persons used more services in the physician, dental, and outpatient hospital categories.
- o There are also differences in expenditures. The differences in Medicaid expenditures are:
  1. Total per capita expenditures (including screening costs) were 36 to 44 percent lower for the screened persons than for the unscreened persons.
  2. Per capita expenditures for inpatient hospital services were 47 to 56 percent lower for screened persons than for unscreened persons.
  3. Per capita expenditures for pharmaceuticals were 18 to 21 percent lower for screened persons than for unscreened persons.
  4. Per capita expenditures for physician services were 6 to 65 percent higher for screened persons than for unscreened persons.
  5. Per capita expenditures for dental services were 17 percent higher for screened persons than for unscreened persons in the test community. However, these expenditures were 2 percent lower for screened persons than for unscreened persons in the control community.

PRINCIPAL FINDINGS: (Continued)

6. Per capita expenditures for optical services were 71 percent higher for screened persons than for unscreened persons in the test community. However, these expenditures were 3 percent lower for screened persons than for unscreened persons in the control community.

TOPICS COVERED:

Child Health/EPSDT Services

- Assessment/Screening

  -- Medical - physical examination - vision

- Hospitalization

Program Management Functions - State and Local

- Program Development

  -- Evaluation - Cost

COMMENTS:

The CHAIRMAN. Our next panel consists of Dr. Cornely, a professor of maternal and child health, John Hopkins University, Baltimore, Md.; accompanied by Dr. Don Blim, the president of American Academy of Pediatrics, Kansas City, Kans.; Dr. John Gartland chairman of the Department of Orthopedic Surgery, Jefferson Medical College, Philadelphia, Pa., on behalf of the American Academy of Orthopedic Surgeons.

I would just say at the outset that your entire statements, if you have written statements, will be made a part of the record.

You can proceed in any way that you wish. We are having some time problem this morning because of votes on the Senate floor.

Dr. Blim.

Senator HEINZ. Mr. Chairman, let me just say that I am delighted to welcome Dr. John Gartland from Philadelphia, Pennsylvania here.

Thank you for introducing him.

The CHAIRMAN. Oh, excuse me.

Senator HEINZ [continuing]. If you had not done so, I was going to do so. You have given him a very fine, thorough, proper introduction.

Dr. Gartland, I won't be redundant, but we welcome you to the committee.

STATEMENTS OF DONALD CORNELY, M.D., PROFESSOR OF MATERNAL AND CHILD HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD., ACCOMPANIED BY DON BLIM, M.D., PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, KANSAS CITY, KANS.; JOHN GARTLAND, M.D., CHAIRMAN, DEPARTMENT OF ORTHOPEDIC SURGERY, JEFFERSON MEDICAL COLLEGE, PHILADELPHIA, PA., ON BEHALF OF THE AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS; ACCOMPANIED BY DAVID MURRAY, M.D.

Dr. BLIM. I am Dr. Blim from Shawnèe Mission, Kans., a practicing pediatrician and president of the American Academy of Pediatrics.

I would remind you that pediatricians have long been involved with the Federal Government in child advocacy programs dating back to 1912 of the Childrens Bureau; 1921 of the Sheppard-Towner Act; 1935, the Social Security Act. In fact, at that time over 50 years ago that was the genesis of the foundation of the American Academy of Pediatrics. For the past 46 years, the Academy of Pediatrics and pediatricians have been vigorously involved in maternal and child health, and specifically crippled children's programs.

Dr. Cornely.

Dr. CORNELY. Thank you.

I would just like to comment on the prepared work from the American Academy of Pediatrics and draw the committee's attention to five issues which we highlight in our written testimony.

The first has to do with a request that the administration has made to you that you set aside title V of the Social Security Act and the academy recommends against that action.

We suspect that the administration simply did not understand the purpose that this committee has intended in sustaining this act over four decades.

It is and has been the legislative base expressing this Nation's recognition of the special vulnerability of children and their special health needs.

If the purpose of block grants is to make it more efficient for States to receive money, title V now says that 90 percent of the money does go to the States so it is very efficient.

But also if it is supposed to draw attention to effectiveness, title V does demonstrate effectiveness. Every State has an unquestioning commitment and focused attention to mothers' and children's health, and we believe that this effectiveness is due to structural components in title V which you should not treat lightly.

One is that each State is required to have an administrative unit distinctly concerned with the health of mothers and children; that this unit in each State must develop a State plan for maternal and child health; that this unit in each State must supervise the expenditure of Federal and State funds for maternal and child health.

We think that experience and that structure is critical. Without the structure, we cannot understand how you are going to insure any effectiveness.

Now, there are three components that will also be lost if you set aside title V which we think are critical to a national direction of a State-by-State effective maternal and child health program.

One has to do with some discretionary funds in title V which give the Secretary the capability to explore special projects of regional and national significance.

The second has to do with some training capabilities to prepare people to implement the very services which you and the States are expected to provide.

The third has to do with some research on the delivery of services, a research capability quite distinct from NIH, and it is a very, very great oversimplification for the administration to say that we will simply transfer those responsibilities to NIH.

We also make the point, Senator, that you should now take this opportunity to consider a reorganization in the Department of HHS, and put together maternal and child health administration.

This administration would, in our view, at this moment assign to it the responsibility for the administration of title V and the EPSDT portion of title XIX. That portion addresses 12 million poor children. That is an exclusive audience of children, and it says to get them into some continuing effective health care system. That is the kind of talents that title V would bring to that.

We would think it would be logical thereafter to assign to that office the administrative responsibility for the numerous disease-by-disease type of projects which come out of other committees in the Congress.

I finally would ask you to recognize that the administration should be required to delineate before the fact what specific data they are going to be able to provide you so that this time next year, you are not faced with a situation where someone has to say we

don't know what happens to these moneys because every State used them differently.

That is an intolerable situation.

As far as the block grants are concerned, we find that the blocking, as proposed by the administration, would further fragment a maternal and child health program capability in the States. In one block, called preventive block you have got six projects in there where the exclusive audience is maternal and child population.

In the health services block, you have three that are exclusively for maternal and child health population.

Putting them into two separate blocks, forcing them to compete with the other components of those blocks makes no sense to us; does not facilitate, as we see it, the State's capability of organizing its services to mothers and children.

We would rather draw your attention to the opportunity to put these things together so that you can forge an effective maternal and child health program State by State.

Thank you.

Senator ARMSTRONG. Thank you, Doctor, I appreciate that very much.

Dr. Gartland.

Dr. GARTLAND. Thank you, Senator, I would like to introduce Dr. David Murray, who is with me today. He is a professor of orthopedic surgery at the Upstate Medical Center in Syracuse and will be the next president of the American Academy of Orthopedic Surgeons.

I would like to request that the written statement that we submitted be made part of the record.

Both Dr. Murray and I are practicing orthopedic surgeons in addition to teaching it.

We are here on a rather small point compared to the testimony I have heard this morning. We are here to specifically ask you not to include the crippled children services in the single health services block grant because we believe this will seriously impair the quality of the medical care that these children receive.

The children we are concerned with, through no fault of their own, are born with or develop significant abnormalities of the arms, legs, spine or joints which make it difficult for them to become productive and independent.

As orthopedic surgeons, it is our responsibility to assist these children become whole again. I would like to point out that this is a responsibility we take quite seriously. I am speaking today for 10,000 orthopedic surgeons in this country, many of whom will provide the care for these children, but all of whom will take great pride in the excellent programs of superb quality that have been built in every State of this country under the present funding mechanisms through title V.

I have dealt with the crippled children services in Pennsylvania and I believe I can point out to you and can predict what will occur if these services are lumped together in a single block grant with such programs as high blood pressure control, migrant health, alcohol, and drug abuse.

We have in my State an orthopedic review panel which evaluates physicians and hospitals seeking permission to start crippled chil-

dren clinics. I have been a member of that review panel for years and I can assure you that if the orthopedic surgeons' qualifications are not of the highest order, and if the hospital and supporting services are not first-rate, permission is denied. This is necessary because specialized education and skills are required to perform the type of reconstructive surgery that we do on these crippled children.

The State of Pennsylvania also maintains a crippled children's hospital near Harrisburg. The children with the most difficult orthopedic problems are sent there for treatment.

Along with other orthopedic surgeons, professors of orthopedic surgery from three of the State's seven medical schools consult there regularly, examine these children, plan their treatment and perform much of the surgery. The hospital enjoys a nationwide reputation for the quality of the care it provides.

Since 1974, we have been arguing with various secretaries of health in Pennsylvannia who wish to close this facility because of costs.

Their argument is that these children should receive their medical care, their orthopedic care in their home communities from their own orthopedic surgeons.

This is a compelling argument if you look at it solely from the standpoint of cost, and I think the block grant mechanism will allow States to do just this.

In our State, if you look at it from the medical viewpoint, I think our peer evaluation system will disappear. I think our crippled children's hospital will disappear. I think that will happen in other States.

Removing the crippled children's services from title V of the Social Security Act and putting it under a single block grant would, in our view, seriously impair the quality of the medical care these children can receive.

All men are not created equal. All orthopedic surgeons are not created equal. All hospitals and hospital supporting services are not created equal and we need to maintain the quality that we have now. The crippled children in this country deserve better than that from all of us, and I would ask this committee not to allow this to occur.

On behalf of the orthopedic surgeons of this country, I would like to thank you for the opportunity of presenting our views.

Senator ARMSTRONG. Thank you very much, doctor.

[The prepared statments of the preceding panel follow:]

STATEMENT OF JOHN GARTLAND AND DAVID MURRAY

Principal points

The Crippled Children's Program is the major nationwide health care delivery system for handicapped children.

Merging this activity with programs for other population segments places the health care needs of mothers and children in jeopardy.

Title V funds are distributed to states on a formula basis, and thus is currently a block grant.

The states are required to match a portion of the Federal dollar and this may be lost under the President's proposal.

This program has been effective and efficient with over 700,000 crippled children receiving services in 1981.

Mr. Chairman and members of the Committee, I am John Gartland, M.D. I am Chairman of the Department of Orthopaedic Surgery at the Jefferson Medical

College in Philadelphia, Pennsylvania and a past President of the American Academy of Orthopaedic Surgeons. With me today is Dr. David Murray, Chairman of the Department of Orthopaedic Surgery at the Upstate Medical Center in Syracuse, New York and currently the First Vice President of the American Academy of Orthopaedic Surgeons.

I am pleased to have this opportunity to appear before you today on behalf of the 10,000 members of the American Academy of Orthopaedic Surgeons to offer counsel to this Committee regarding the Maternal and Child Health Programs under Title V of the Social Security Act and, in particular, the Crippled Children Services supported by that title.

Mr. Chairman, as orthopaedic surgeons, we spend a fair amount of our time diagnosing and treating children afflicted with crippling disorders, such as congenital disclocation of the hip, club feet, spina bifida, and cerebral palsy.

The Administration is proposing to merge the Title V programs into a single block grant along with such health service activities as alcohol and drug abuse programs. We believe this is a serious mistake.

Title V has been the basic vehicle to promote and protect the health of mothers and children in this country. The crippled children's programs currently constitute the major nationwide health care delivery system providing services to handicapped children. This program provides support for locating, diagnosing, treating and hospitalizing children who are crippled or suffer from conditions which lead to crippling.

In every state throughout the Nation teams of medical specialists, pediatricians, nurses and allied health personnel work together to provide the special services required by these children. In 1981 alone over 700,000 crippled children will receive services under this program.

Our specific concern is that any merging of this program with programs aimed at other population segments places the health care needs of mothers and children in a position of jeopardy. Our concern simply stated is that mothers and children may not be able to compete effectively with the myriad of programs proposed to be included in the Administration Health Services Block Grant.

The present Title V program is, in our opinion, a block grant. The funds are distributed to the States through a formula which relates the amount of the Federal grant to an identified need within that State.

Also, under this Title, each state must identify a distinct administrative unit to develop a State plan to extend and expand maternal and child health and crippled children's services. Furthermore, that unit is required to supervise the utilization of Federal and State funds in the implementation of the plan. Thus, the necessary administrative controls are in place and working for the public.

Most importantly, the current Title V legislation requires the States to match a portion of the Federal funds received. However under the administration's proposed Health Services Block Grant, it is not clear to us whether or not the states would be required to continue to match a portion of the Title V money. This potential loss of financial support will, we believe, severely impact on the level of services that will be available in the future to crippled children. If these children do not receive the care they need, if they are not given the opportunity to become productive citizens, then they will become burdens to society and we are simply shifting the cost and responsibility from this title to some other government program—most likely welfare.

Mr. Chairman, while we support the President's goal of reducing inflation, improving the management of governmental programs and eliminating unnecessary regulations which contribute to the spiralling cost of health care, we believe that the proposal to merge the maternal and child health programs with other activities is a step in a direction that is opposite to the one publicly chosen by the President.

We believe that Title V has been an efficient and effective block grant to the States. It is helped those individuals in our society most in need of help. It is our belief that the strengths of this program should be retained and built upon—and not cast aside. Congress over the years has shown its wisdom in providing this type of support for our children and we urge this Committee to continue that support.

Mr. Chairman, Dr. Murray and I will be happy to answer any questions you may have regarding this program.

STATEMENT OF R. DON BLIM, PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS AND DONALD CORNELY, PROFESSOR OF MATERNAL AND CHILD HEALTH, JOHNS HOPKINS UNIVERSITY

AMERICAN ACADEMY OF PEDIATRICS—SUMMARY OF STATEMENT

I. A discussion of the Title V (Maternal and Child Health/Crippled Childrens) Program—the intent of the law and scope of the programs.

Recommendation: The American Academy of Pediatrics finds that Title V has been an effective and efficient program and is needed as the basic underpinning for a national focus to assist states in advancing the health of mothers and children. If this program is set aside in favor of a block grant which does not contain the special features of Title V, we cannot understand how the expressed intent Congress has set forth for over four decades can be pursued, much less achieved. We strongly recommend that you sustain Title V as a necessary component within the block grant concept proposed by the Administration.

II. A discussion of Grant-in-aid to States—the need to combine compatible programs or projects into one package or block to the states.

Recommendation: The development of a maternal and child health "block grant," based on the Title V program to encompass the following programs: MCH-CC programs, genetic diseases, SIDS, SSI, family planning, adolescent pregnancy, and hemophilia. This would greatly facilitate the capacity to plan for and deliver health care services for mothers and children and avoid the fragmentation and duplications the Administration intends to correct. It would be possible under this approach to have each state develop a maternal and child health plan were choices of emphasis are related to the needs of this population in each state.

III. A discussion of the need to reorganize maternal and child health services within the Department of Health and Human Services, including the relationship of Title V and Title XIX.

Recommendation: The creation of a single Maternal and Child Health Administration within DHHS. Such an Administration would strengthen maternal and child health programs, reduce fragmentation and duplication of efforts and would not involve additional expenditures.

IV. A discussion of the need for a data base, including federal requirements and state accountability.

V. A discussion of the need to recognize and support training and research as a responsibility of the federal government.

The American Academy of Pediatrics, as the professional association of physicians in this country who specialize in the health care of children and adolescents, appreciates this opportunity to offer counsel to this Committee as you consider the proposal of the Administration on federal-state relationships in the health care of children. We wish to draw your attention to five issues we judge of paramount importance in the organization and administration of maternal and child health services.

At the outset, we want to emphasize our vigorous support for the goals the President has expressed to reduce inflation, to reaffirm the importance of the states' role in the administration of local health services, to reduce the fragmentation of efforts, and to eliminate unnecessary regulations which hamper the states in their implementation of health programs.

1. Title V Social Security Act

The Administration proposal, as we understand it, would set aside Title V of the Social Security Act and substitute as grant-in-aid to the states a basic health services block grant which would incude maternal and child health services as one of the group of health services. We would question the Administration's understanding of the role and purpose of Title V at the national level and in the federal-state relationships for maternal and child health services. We deem it most imprudent to set aside Title V.

Your predecessors in every Congress since 1935, when the original Social Security Act was passed, have exressed their support for Title V as the basic vehicle to promote and protect the health of mothers and children in this country. Title V was included in the original Social Security Act because Congress wished to acknowledge the special vulnerability of children and their need for special attention in matters of health services. This Committee has reaffirmed this commitment to children continuously over the 46 years that Title V has existed and has been joined in this effort by public and private groups across this country.

This Committee recognizes that Title V from its inception has been a block grant-in-aid to the states for maternal and child health services. This mandate has required that 90 percent of the Title V appropriation be utilized as grants to states

through a formula which relates the amount of the federal grant to need as it varies across the states. However, Title V has incorporated other features in this federal-state partnership which have made this a most effective and efficient program.

Each state is required by the Title V legislation to identify a distinct administrative unit to develop a state plan to extend and expand maternal and child health and crippled children's services and to supervise the utilization of federal and state funds in the implementation of the state plan. Each state is required to match a portion of the federal funds awarded until Title V and it has been a fact for many years that the states exceed their required match. The effect of these special requirements in Title V has been to stimulate in every state an unmistakable commitment to health services for mothers and children and to avoid the very real risk that this segment of our population would receive insufficient attention. A general health effort in which the vast bulk of expenditures is assigned to other population segments places health services for mothers and children in a hopelessly weak competitive position. This insistence on a distinct effort for the health of mothers and children in each state is the heart of Title V and is what has been responsible for its retention and splendid record of accomplishments over nearly half a century. Removing these special features would place this dependent segment of our population in competition with the needs and interests of the entire population and repudiate the recognition that Congress has expressed for the mothers and children. This Committee knows very well that while children constitute 50 percent of the Medicaid enrollees, they command no more than 10 percent of Medicaid expenditures. It is not difficult to understand the weak competitive position children's health needs have under such circumstances.

Thus, the idea of a block grant-in-aid approach to the states for health services is not new to this Committee or to those who administer Title V programs in the states but the goal is to improve the health of mothers and children through the means of a federal-state grant-in-aid. The grant-in-aid is not the goal. The recognition that each state can best decide its individual needs is also a means toward the goal of improved health of mothers and children. The structural features of Title V are also means which assure attainment of the goal.

The American Academy of Pediatrics is concerned that in making this current proposal, the Administration did not appreicate what Congress intended in establishing and sustaining the Title V program. Congress expressed in Title V a clear recognition that the health of mothers and children cannot be equated simply with being ill, with being hospitalized, or even with being poor. Rather, it is the fact that all children require special attention becaust they are growing and developing and these unique characteristics of infants and children present a dimension of health not seen in other segments of a population. So long as a society has children, it must surround them with the minimum requirements to assure they progress through childhood in a manner conducive to their functioning later as adults. Title V is not a project limited in time, it is a health program that must exist simply because children exist. The frequency of illnesses in children might change over time, but there continues over all time and for all children a deliberate attention to other aspects of their health. It is necessary that someone address the development and promulgation of standards of care for women during their pregnancies and for care of newborns in nurseries. Someone must be responsible to identify those women who are pregnant and not receiving prenatal care and those children whose access to or utilization of health services is compromised by factors of poverty, rurality, unfavorable family conditions, or working parents. Someone must pay attention not only to those mothers and children who are receiving care but those who are not but who need health care. Someome must study the basis for inadequacies in health care to mothers and children and propose solutions to such circumstances. In a word, the health needs of a maternal and child population cannot be met simply by a series of disease directed projects. Maternal and child health services in each state involve setting of standards, development and deployment of resources, demonstrations of new and improved arrangements for assessment and care, and the delineation of resources required in terms of facilities, personnel and financing.

Title V was never intended by Congress to be a separate health care system for mothers and children. In fiscal year 1981, the total federal appropration for Title V was approximately $400 M. That calculates out at an average of $5 per year for every child and woman of childbearing age, and thus there is no ambiguity that Congress never intended Title V to be a separate system or the means for financing personal health care services to the maternal and child population. Rather, Title V intends what the language of the Act states, "to enable each state to extend and improve the health services." Title V has the mission to organize new and better programs, to fill in gaps, to undertake demonstrations and to raise standards. The

activities of a Title V program range from advocacy and case finding to education of the public and the needs assessment for mothers, children and particularly for children with special needs as represented by the original language of "crippled children."

This Committee bears a special responsibility to these concepts of maternal and child health. This Committee understands most vividly why the commitment of this country to special attention for the health of mothers and children was included in the Social Security Act rather than simply being pursued as a more circumscribed health legislative effort. This Committee's heritage is a recognition of the special vulnerability of children. The American Academy of Pediatrics has an equally rich heritage on the specific issue now being considered by this Committee. You should know that the American Academy of Pediatrics was founded in 1930 as a response by this country's pediatricians to support a grant-in-aid concept for states to develop a distinct unit and plan for the health of mothers and children (Sheppard-Towner Act). We are as proud of that heritage as this Committee is of its special contribution over the ensuing half century and it is this common purpose which encourages us to share our judgments with you at this time.

In addition to the 90 percent of Title V funds which are allocated as grants to the states, there are three other components to this Act which you should preserve. The Administration proposal would eliminate these components. I refer to the discretionary funds available to the Secretary to support "special projects of regional or national significance which may contribute to the advancement of maternal and child health or services for crippled children." This is a very desirable and important means to accomplish the basic purpose of Title V and should not be deleted. It currently represents approximately $38 M and is used for a variety of efforts ranging from assistance in developing transport systems for ill newborns to training of nurse-midwives, nutritionists, social workers and physicians who choose to focus their professional activities on implementing the Title V program in the various states.

The second component the Administration proposes to eliminate is a very important and small effort for training a variety of personnel for work with children with mental retardation and also with children who have chronic pulmonary disorders through University Affiliated Facilities. This component of Title V, Section 511, has received $26 M in the current fiscal year. Finally, the third component that is proposed to be eliminated is a very modest research effort being funded currently at $5.3 M. This research effort is very distinct from that of the mission of N.I.H. since its focus is on projects which show promise of substantial contribution to the advancement of maternal and child health or crippled children's services. This research effort attempts to improve the functioning of the Title V program in the states and is a needed distinctive complement to the basic science research mission of the N.I.H.

The American Academy of Pediatrics finds that Title V has been an effective and efficient program and is needed as the basic underpinning for a national focus to assist states in advancing the health of mothers and children. If this program is set aside in favor of a block grant which does not contain the special features of Title V, we cannot understand how the expressed intent Congress has set forth for over four decades can be pursued, much less achieved. We strongly recommend that you sustain Title V as a necessary component within the block grant concept proposed by the Administration.

2. Grant-in-aid to States—Maternal and child health program

The Administration has proposed aggregating health projects and programs which function in the states into two block grants as a means to make it more efficient for states to obtain such federal grant-in-aid. The two health blocks proposed are the Preventive and Health Services Blocks.

In each of the proposed Blocks there are categorical health projects which contain both preventive and illness care components and thus the proposed assignments into either Block are, at best, arbitrary. In each of the proposed Blocks, there are projects in which the focus primarily is the maternal and child population. Such an arrangement of projects spread over two Blocks will accentuate fragmentation of a maternal and child health program in the states. In each of the proposed Blocks there are projects which are not logical to be aggregated with others as it does not facilitate the states in making choices of emphasis within a useful framework. Finally, in each of the proposed Blocks there are projects which when authorized and subsequently funded were never intended to be found in every State. It would be possible for a state which did not previously have a given project in its health program simply to avoid initiating such activities under the proposed block approach. However, there are also projects which should be in every state health program even though they were not previously present. An example of the latter

situation is the Adolescent Pregnancy Projects for which the authorization used a competitive project approach and the appropriation permitted only a finite number of project awards. Without additional funds, states would be required to develop adolescent pregnancy projects at the expense of other existing projects. These circumstances prompt the Academy to consider the proposed Blocks an unsound approach to promote an appropriate health program for mothers and children in the states.

We recognize that the process of federal grant-in-aid to the states involves actions which have a tendency to develop imbalances over time. On one hand, regulatory actions are required to ensure that the aid is effective in its use for the authorized purpose. On the other hand, actions must also be taken to facilitate the states' capacity to receive and apply the aid efficiently. While some grants-in-aid are entitlement awards to all states, other grants are competitive awards and not found in all states. These seemingly competitive components of the grant-in-aid process on any issue or topic do necessitate adjustments from time to time lest imbalances which develop frustrate the ability of the aid to achieve its purpose. Congress has the capacity to make adjustments in every grant-in-aid it authorizes so as to strike an appropriate balance between the forces of efficiency and effectiveness.

Combining several programs or projects into one package or block would improve the efficiency of the states to receive grant-in-aid. Attention must be paid to the projects chosen to be grouped into a block package lest the effectiveness of each categorical project in the package is jeopardized. Six of the projects in the proposed Preventive Health Block and three of the programs or projects in the Health Services Block focus essentially and exclusively on the maternal and child population. These nine programs or projects are: maternal and child health (Title V and XVI, Social Security Act), hemophilia, sudden infant death, immunization, fluoridation, lead-based paint poisoning prevention, genetic disease, family planning, and adolescent pregnancy.

When one realizes that the maternal and child population constitutes just under 75 million individuals and is aware of the numerous categorical projects which focus on some aspect of maternal and child health, what each state needs is the capacity to develop a comprehensive program in maternal and child health rather than fragments here and there.

The Academy recommends that the emphasis be on the development of the appropriate maternal and child health program in each state with assignment of authority for the administration of all categorical health projects whose focus is the maternal and child population. This would greatly facilitate the capacity to plan for health care services to mothers and children and avoid the fragmentation the Administration wishes to correct. It would be possible under this approach to have each state develop a maternal and child health plan where choices of emphasis are related to the needs of this population in each state. Having a strong maternal and child health plan and program will not lessen the capacity for integration and coordination of all health services within a state health program. We are not proposing a separate health system for mothers and children but rather an assurance that the states can organize and execute these responsibilities to the entire population. Separateness is not the emphasis, it is the attention to a logical aggregation of projects and programs where standards can be established and maintained. It should ensure both effectiveness and efficiency.

3. Reorganization of maternal and child health services in DHHS

This Committee has responsibility for the Medicaid program which includes the distinct component, EPSDT. The EPSDT effort focuses on the approximately 12 million poor children who are eligible to be enrolled in the Medicaid program. The purpose of EPSDT is to recruit every child enrolled under Medicaid into a health program which will provide an adequate continuing source of personal health care and to promote periodic assessments of health status of these children. The tasks involved in implementing the purpose of EPSDT are those implicit in the Title V mandate. The Academy has endeavored for many years to cooperate with and assist those responsible for the EPSDT Program and the history of our efforts will document our good faith. To date, however, the EPSDT Program has failed in its objective of introducing children into the medical care system existing in their communities to provide for their immediate and future health needs. Extensive revisions must be made in this program and we would urge that this Committee hold oversight hearings in this regard.

As you know, the administration of Title V and EPSDT while in the same Department are in entirely different administrative units. The Academy judges it would be both more effective and efficient to have these two programs administered by the same staff. We recommend that this Committee develop legislation to establish a single Maternal and Child Health Administration within DHHS and assign

this unit the responsiblity for administering Title V and EPSDT. Such a move would strengthen both programs, reduce the fragmentation represented by the existing administrative structures and would not involve additional expenditures. Ultimately, this union for administering the Title V and EPSDT programs should also occur in each of the states. We recommend this Maternal and Child Health Administration be assigned to the Public Health Service where Title V now exists. The financing responsibilities for Medicaid would remain in the Health Care Financing Administration.

Once such a distinct unit is established, it would be logical to assign to it other existing and new health legislation which focus on mothers and children. At this time, the Genetic Diseases and Sudden Infant Death Syndrome projects under the Public Health Service Act are assigned to the same office which administers the Title V program in DHHS. There are additional project authorities being considered by the Committee on Labor and Human Resources which would be desirable to assign to the new Maternal and Child Health Administration. These projects include Immunization, Fluoridation, Lead-Based Paint Poisoning Prevention, Family Planning and Adolescent Pregancy.

4. Data base for block grants to States

This Committee understands that it will be necessary to monitor not merely the process by which federal funds are passed to the states bût also what has been the effect associated with the use of such funds. Your need for accountability of the use of these funds is an important consideration when next year's budget proposal is to be considered. Similarly, this Committee will need to know what needs have not been able to be met with the block grant approach. You cannot risk simply being told that it is not known what was accomplished by the appropriation because the funds are used differently in each state. You cannot meet your responsibilities to adjust those programs you set in place if the accomplishments and deficiencies resulting from block grants are not provided. The Administration must be required to identify before the fact its plan for assembling appropriate data relative to the effect of the block grant authorized.

You must insist that you receive information on the services provided to women surrounding reproductive health, including antepartum, intrapartum, postpartum and family planning services. Similarly, you should require adequate information on those women in need of such services who were not able to be served through the block grant approach. You should insist that sufficient details be presented to identify the circumstances which prevent these women from receiving needed health services and what is proposed to meet such need. The same detailed information should be required for infants, children and adolescents regarding health services provided and where such services could not be provided. Since block grants as proposed by the Administration are being combined with budget reductions, the Administration must understand its responsibility to provide a comprehensive assessment of their positive and negative effects.

5. Training and research

The Academy emphasizes the need to recognize that training and research support is a responsibility of a national program and not that of the states. In many of the projects and programs proposed to be grouped into block grants there now exist specific training and research components which Congress authorized because of the special issues addressed in such projects and programs. It is not clear how these efforts will receive appropriate attention under the proposal of the Administration.

In some instances, the Administration has simply indicated these efforts will be the responsibility of the N.I.H. Adding these responsibilities to N.I.H. without assurances that funds are earmarked for these specific purposes is not sufficient. We are concerned that training and research for the health services are being viewed as expendable in the present budgetary climate. Reductions in the budget that are so severe as to eliminate training and research components of health services programs, as is proposed for Title V for example, is not sensible. Many of the projects in the proposed Preventive and Health Services Block Grants require personnel with special preparation for intelligent implementation. Similarly, systematic study of the problem to be addressed by projects and programs in the proposed block grants is no less important than when the issues are energy or defense. The training and research efforts require support at the national level.

Senator ARMSTRONG. Is Dr. MacQueen in the room?

Doctor, would you also please come up to the table?

I believe you are our last witness.

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Dr. MacQueen is the vice chairman of the select panel for the promotion of child health, Washington, D.C.

Dr. MacQueen. Shall I continue now?

Senator Armstrong. Please do.

STATEMENT OF JOHN C. MacQUEEN, M.D., VICE CHAIRPERSON OF THE SELECT PANEL FOR THE PROMOTION OF CHILD HEALTH, WASHINGTON, D.C.

Dr. MacQueen. Mr. Chairman, 2 years ago the Congress charged the Secretary of Health to create a select panel for the promotion of child health. The panel was charged to formulate specific goals for national health for the Nation, develop a comprehensive plan.

We spend some 18 months. We interviewed representitives of the various professional societies, studied reports. We held studies around the Nation. The select panel gave particular attention to this matter of the Federal programs, particularly, the title V program.

This is included in one of the chapters, chapter 2 of the four chapters that were developed by this panel.

Rather that attempting to summarize this report, since it is essentially telephone books in size, I would just like to comment on three major issues that show a difference between the opinion of the panel and the proposed legislation.

Generally speaking, the administration's proposal to repeal the authorizing legislation, such as title V for the various Federal child health programs, and to enact new legislation creating unrestricted health service blocks would represent, in our opinion, a radical departure—a radical departure from a long and well-established Federal policy to protect children and mothers.

I would like to speak about three issues—three major issues. The first of these, the select panel identified the need for a strong Federal leadership role in improvement of child health services, and this is in contrast to the position that is taken by the administration policy.

The select panel found that the Federal Government has, in fact, exerted a very beneficial role vis-a-vis the States and localities in improving the delivery of maternal and child health services. And that the administration proposal to establish unrestricted health service block grants for the States would essentially eliminate, certainly substantially reduce that Federal leadership role.

The second of the major issues concerns the one of targeting funds. The select panel studied and decided not to support the creation of unrestricted block grants for basic health services during our studies.

It can be found that experience shows that, children and infants who have no political voice, cannot compete successfully at the State level with other interests.

I would take you to yesterday when I was in my State with a task force called by my Governor to look for the first time at how our State would respond to this decision.

I would describe that meeting as one of, at least, confusion, if not alarm, and a great concern of what this would mean.

Senator Armstrong. Your State is?

Dr. MacQueen. Iowa.

Senator ARMSTRONG. Iowa.

Dr. MACQUEEN. Who was there in numbers, particularly mental health. It would be very difficult, the group that gathered there, to expect that children and mothers would have a fair shake or an equal shake, and the political decision was made in the framework of who was there.

So, we are very concerned about that.

The third issue that the select panel found was the need to return more strength to the communities and to the States.

We propose a redefining of responsibilities, establishment of a true balance between Federal, State and communities. And this is in conflict with the administration's policy that would return essentially all the responsibilities to the States.

Thank you.

Senator ARMSTRONG. Thank you.

[Statement follows:]

STATEMENT OF JOHN C. MACQUEEN, M.D., VICE CHAIR, THE SELECT PANEL FOR THE PROMOTION OF CHILD HEALTH

Two years ago, Congress charged the Secretary of Health to create a Select Panel for the Promotion of Child Health. This charge is included in Section 211 of the Health Services and Centers Amendments of 1978 (P.L. 95-626).[1]

The law stated that the Panel should be composed of fifteen members, not less than three nor more than five employed by the Department of Health, Education, and Welfare. The remainder of the members will be representatives of the scientific, medical, dental, allied health, mental health, preventive health, public health, and education professions as well as consumers and representatives of state and local agencies.

The specific charge to the Select Panel was as follows:

"1. The Panel, after reviewing all the significant medical, scientific, behavioral, and epidemiological studies concerning the promotion of maternal and child health . . . shall:

"A. Formulate specific goals with respect to the promotion of the health status of children and expectant mothers in the United States;

"B. Develop a comprehensive national plan for achieving these goals and otherwise promoting the health of children in the United States; . . ."

The law further stated that the Panel should report to the Secretary and to the appropriate committees of Congress[2] its recommendations for administrative, legislative, and other actions to implement the plan.

To respond to its charge, the Select Panel studied all aspects of maternal and child health. This was done by requesting recognized experts in the field to develop background papers, by studying available literature and reports, and by conducting public hearings in cities througout the nation. The result of this eighteen month effort is recorded in four volumes that are no doubt the most comprehensive current statement about the health status of the nation's mothers and children.

The Select Panel gave particular attention to federally funded health programs for mothers and children. One major focus of the Panel's report is Title V of the Social Security Act, over which your Committee has jurisdiction. As you are aware, the title V Maternal and Child Health Program provides health services to indigent pregnant women, mothers and small children. The Title V Crippled Children's Program provides specialized health services to handicapped children who would not otherwise have access to such services because of their unavailability in a particular geographic area or because of poverty. Another component of Title V is a research and demonstration project and training program aimed at the improvement of the delivery of child health services.

In addition to the Title V programs, the Panel reviewed in detail the following federal child health programs: Title XIX of the Social Security Act (Medicaid) and the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program; the Supplemental Food Program for Mothers and Children (WIC); the Education for All

[1] The panel is governed by the provisions of Public Law 92-463, the Federal Advisory Committee Act, which sets forth standards for the formation and use of advisory committees.

[2] The Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Human Resources of the Senate.

Handicapped Children Act (P.L. 94-142); and the Mental Health Systems Act. The Select Panel also looked at other child health programs such as the National Genetic Diseases Programs, the Sudden Infant Death Syndrome (SIDS) Program, the Family Planning Services Program, and the Adolescent Pregnancy Program.

I would like to submit for the record, the Select Panel's report entitled, "Better Health For Our Children: A National Strategy," which contains the Panel's findings and recommendations. Rather than summarizing this report, I think perhaps what might be most useful to the Committee would be for me to comment briefly on the Administration's proposals with respect to federal child health programs.

The Administration's proposal to repeal authorizing legislation, such as Title V, for the various federal child health programs and to enact new legislation creating an unrestricted health services block grant would represent a radical departure from a long and well established federal policy to protect a very vulnerable segment of the population, namely infants and children with actual or potential health problems. These proposals are contrary to and inconsistent with the Panel's findings and recommendations.

The Select Panel identified a need for a strong federal leadership role in the improvement of child health services. The Select Panel found that the federal government has, in fact, exerted a beneficial leadership role vis-a-vis the states and localities in improving the delivery of maternal and child health services. This leadership role has been facilitated by the existence of the Office of Maternal and Child Health in the Department of Health and Human Services, which has served at least in part as the locus of responsibility for federal child health activities. The Office has performed the valuable function of disseminating to states and localities for their guidance, child health care standards based upon national standards formulated by the medical profession as a whole. Moreover, much of the progress in recent years in the improvement of the delivery of maternal and child health services at the state and local level is attributable to the Title V research, demonstration projects, and training programs which are administered by the Office and which have provided child health service delivery models and trained personnel for states and localities. In addition, the Office has provided technical assistance to the states in formulating and implementing a state plan for maternal and child health services.

The Reagan Administration's proposal to establish an unrestricted health services block grant for the states would essentially eliminate or substantially reduce the aforementioned federal leadership role. No provision is made under the Administration proposals for an Office of Maternal and Child Health at the federal level, which would formulate national child health goals and standards, organize research, demonstration projects, and training activities and provide technical assistance to states and localities. It should be noted that every other industrialized country in the world has a governmental unit charged with carrying out national policy with respect to child health.

The loss of federal research, demonstration projects, and training activities is particularly troublesome inasmuch as most states do not have either the resources or expertise to undertake such activities on the needed scale. Even assuming that such activities are continued in some form at the federal level, it is unlikely that these activities will be organized so as to give adequate prominence and visibility to child health care without a distinct and separate federal funding stream for maternal and child health services. Under Title V, such activities at the federal level can be directly integrated and coordinated with maternal and child health programs at the state and local level.

The Panel's findings dictate the conclusion that the Administration's proposed block grant for health services without any targeting of monies for child health would also have a devastating impact upon the accessibility to needed health services of mothers, infants, children, and adolescents. The Panel report documents the contribution which federal child health services, especially Title V Maternal and Child Health Services and Title V Crippled Children's Services have made to the betterment of the health status of our nation's women and children. The Panel found that these services, which emphasize prevention, have been instrumental in reducing infant and childhood mortality, morbidity, retardation, and handicapping conditions. Hundreds of thousands of infants and children have grown up to be productive citizens rather than dependent charges upon society because of these services.

The Select Panel did not support the creation of an unrestricted block grant for basic health services which includes child health services like the one which the Administration proposes because this type of a block grant would compel child health programs to compete for funds at the state level with many other unrelated adult health programs. Experience has shown that helpless infants and children

who have no political voice, cannot complete successfully at the state level with "concentrated" interest groups for limited public dollars. Moreover, there is no assurance that the allocation of funds to the states under the proposed block grant would fairly reflect in the future, the differing maternal and child health needs of different states.

It must be borne in mind that the Administration's proposal for the creation of an unrestricted health services block grant would not only eliminate the existing targeting of federal funds for child health services, it would also eliminate any state financial match requirements. At the present time, states receiving Title V monies for child health services must share in the funding of such services. The Select Panel found there to be a great value in a strong state/federal partnership in the area of child health which involves a contribution on the part of state government as well as the federal government to the funding of child health services. Without such a state financial match requirement or state maintenance of effort requirement, the states would have no direct financial stake in the cost-effective management of federally funded child health programs. And, there is reason to believe that without a match or maintenance of effort requirement, many states, which are presently hard pressed financially, would reduce considerably their current financial contributions to federally funded child health programs.

Furthermore, the Administration proposes to reduce overall federal funding for health services by approximately 25 percent. The Administration's proposed block grant which eliminates targeting of monies for child health and eliminates state financial match requirements for federally funded child programs, coupled with the Administration's proposed funding reduction for health services, will inevitably and tragically mean a severe decrease in essential health services for women, infants, children, and adolescents. It should be mentioned in this regard that a significant number of mothers, infants, children and adolescents do not receive even minimal basic health services at the present time and concluded that federal funding for child health programs of demonstrated cost-effectiveness should be increased, not decreased.

I would like to call your attention at this point to the Panel's recommendations for changes in the existing federal child health programs. I believe that the Panel's recommendations reflect a thoughtful approach to the problems associated with these programs that hold out the potential of building upon and reinforcing the best elements of these programs and of eliminating, or at least reducing, their worst elements. One of the Panel's chief recommendations is that Title V be continued as the centerpiece of federal child health policy, that the Title V programs, which have a proven and successful track record, be expanded, and that these programs be used as a core around which other smaller child health programs, can be consolidated. I refer you to the Panel's report for specific and detailed recommendations relating to the reorganization and restructuring of the federal child health effort.

The Panel, in formulating its recommendations was mindful of the fact that the major dilemma of state/federal relations today is insuring appropriate state autonomy in the control and organization of federally funded programs while at the same time insuring state accountability for the expenditure of federal funds, equality of access to services across states, and appropriate service quality. The Panel found that the Title V programs, which it recommends be the major vehicle for federal efforts to improve child health, allow substantial state initiative and authority to determine program content and scope. Thus, Title V requires states to formulate and obtain approval of a state plan for maternal and child health services but it specifies in only the most general terms, the type of services which must be provided and it leaves to the states, the determination of eligibility criteria and method of service provision.

In conclusion, I would like to reiterate that the fundings and recommendations of the Select Panel—based on its 18 month study of child health programs—suggest that enactment of the Administration's proposals with respect to federal child health programs would be a tragic mistake. The future health of the nation depends on the health services provided today's mothers and children. Dollars spent to prevent and treat health problems of mothers and children will determine the health of tomorrow's work force and even the ability of the population in the future to defend itself. The nation can make no better investment than an investment in federal child health programs. As Vice Chairperson of the Select Panel, I sincerely hope that you will give very careful and thoughtful consideration to the Administration's proposals with respect to federal child health programs, and I sincerely hope that you will continue your long standing support of effective and efficient federal efforts to improve child health.

Senator ARMSTRONG. I thank all the witnesses.

I have one question that I would like to throw out.

I am going to address it first to Dr. Cornely because he first raised the issue, but I would be happy to have the other witnesses respond as well if they wish.

The question is this: You mentioned that one of your concerns about the block grant approach, we wouldn't know how the money was spent. All we would know is how much money went out in the States, and that would be intolerable.

I would be glad to have you amplify that, particularly, in light of subsequent testimony because in some degree that is the point of what all the witnesses said is that really, they just don't want those decisions made at the State level.

I'm speaking only for myself, really, but I think it is a fairly general belief that most decisions are better made at the local level. I don't mean decisions about medicine or decisions about any particular subject, but just a general idea that decisions which are made by people closest to the problem, that is, social welfare or where highways ought to go, or you name it, but in general, there is greater wisdom in this county level or the State level than there is in Washington, D.C.

I take it, in essence, the witnesses do not agree with that?

Dr. CORNLEY. I think you misunderstood us, Senator. I think we are emphasizing that—title V now says that the States must make a plan to demonstrate the needs and how it is going to use its money State-by-State. But in order to insure that each State addresses that, and in order to insure that when you appropriate money, that it goes to serve those mothers and children, as opposed to black lung disease for miners, or something else, that you need some structure in the Federal Government.

Senator ARMSTRONG. I don't want to quibble, and I don't want to be argumentative, but it seems to me that that's exactly what you are saying is that local control, but with guidelines that say that you have got to treat specific concerns, but are the concerns of this committee or the concerns of the Congress.

Maybe in West Virginia the belief would be that black lung was the problem of overriding significance. I don't believe it would be in Colorado where I am from.

I doubt if it would be in Iowa, but it seems to me that that's really the issue that we are addressing, not only in this particular program, but in the entire concept of block grants. Either we trust people at the local jurisdiction, or we don't.

Is it your testimony that you really don't think they would make good decisions? that the allocation of resources is something that really ought to be done by this committee or by the Congress?

Dr. CORNELY. Senator, I'd say that if you would look at your medicaid program and realize that half of the number of people who are enrolled are children, and they consume about 10 percent of your money, what kind of a competitive position do you think that population group is in? I think if you turn aside title V, you repudiate what this committee has stood for 46 years. It says: "Children need some special protection because they are not all sick; they are not all poor, but they are growing and developing and they need special attention."

Senator ARMSTRONG. OK. Fair enough. That is not my question.

You are saying that this committee for 46 years—I have only been a member of this committee 2 months, so my experience is limited. You are saying that this committee or the Congress is more likely to adequately protect the interest of some people than our State legislatures or Governors, who are more likely to respond to other pressure? In other words, they just won't make as good a decision as we will here in Washington?

Dr. MacQueen. I think that is the Federal role, to give that leadership, yes, sir. I think there is history that that is true. That the initiatives have come from the Federal Government. That the wisdom must come from the Federal Government. I'm a little reluctant to speak in the absence of Senator Grassley, but the truth of the matter is that the total budget of the MCA's program in the State of Iowa is a Federal program and that I have participated in efforts throughout the years to try to have our State legislature create programs, and without success.

The only program that we have that we have created in the last——

Senator Armstrong. Why is your State legislature so insensitive? You have now characterized your State in most uncomplimentary terms. Why is that?

Dr. MacQueen. Well, I'm loyal to my State, but I would say that that issue is—well, that's a fact, OK?

Senator Armstrong. Well, why? Why is it so much easier to persuade people in this hearing room that the need is great if you can't persuade the people at home?

Dr. MacQueen. I think there is a division of responsibility that is natural. I think at the State and local level to say how to do things is understood, and I think that responsibility should reside with them, but I think there are overriding national goals that are not undertaken by most State legislatures. I have not seen it in my profession.

Dr. Gartland. Senator, I would agree philosophically with your earlier statement about most decisions being made, and probably best at the local level. I find that philosophically I am in agreement with that. I think there are some concerns though, and I think health is one of them. I think taxation is one of them. I think education is one of them that transcends this type of geographic distribution or division, and I think some structure or guideline must come down from the Federal Government, and I believe health is a thing apart from the highways.

Senator Armstrong. In other words, you think it is more important?

Dr. Gartland. I believe it is more important.

Senator Armstrong. Or that the States are least capable of planning highways, but not planning——

Dr. Gartland. Well, I don't want to get into a State discussion because we are not as bad as Iowa; we're not confused, but——[Laughter.]

But my experience with the State health people has been not very reassuring.

Senator Armstrong. What State are you from?

Dr. Gartland. Pennsylvania.

It has not been very reassuring, and I think unless they are directed to do something, the crippled children's services in Pennsylvania will be of historical moment only.

Dr. MacQueen. I respectfully say that they haven't held their first meeting yet to decide how they are going to respond to block grants because I would expect that their reaction would be the same. That is a tough nut. Who is going to be responsible? How are you going to divide that up?

Senator Armstrong. Well, gentlemen, I am grateful for your testimony and I, for one, am certainly going to keep what you said in mind when we get around to this issue for a decision. In general, I do not share your point of view, but the fact that you have expressed it, cautions me that I should reconsider my own position, and I shall do so.

I should also tell you this: that in a very general sort of way, justification that you have advanced to support Federal leadership, or for those of us who don't care for such leadership, in general, Federal control as you call it, the same argument that you would use, has been used to advance every known kind of Federal regulation and regimentation of the State and local jurisdictions.

We can hear that argument advanced in highways; you can hear it advanced in education, in law enforcement, health care. There is scarecely a field of human activity which somebody doesn't think that if left to their own decision, the States will make a mess of it. That may be true. It is not my experience.

While I am new to this committee, this is my ninth year in the Congress of the United States and I served a decade in the State Legislature for Colorado.

I will just tell you that if Washington doesn't have the monopoly, we have certainly got the major U.S. franchise. There isn't any more wisdom here.

In fact, my experience is just the opposite. Decisions made, at least in my State, tend to be less political, less subject to irrational pressure, or keyed to the real needs of the public. I can't say that for every State. In fact, I have a hunch my State is a bit more progressive in that respect than most, but it is a basic philosophical question, but, of course, it is also a practical question of whether or not block grant proposals will fairly meet the needs of crippled children and the other interests that have been represented here today.

Thank you so much. I compliment you for coming.

We are going to adjourn this hearing, but I am asked to announce that the last day of hearing on the administrative budget reduction is scheduled tomorrow at 10 o'clock.

The witnesses will be David Stockman, Director of OMB and Governor Matheson from the State of Utah.

Thank you all.

The meeting is adjourned.

[Whereupon, at 12 noon, the hearing adjourned, subject to the call of the Chair.]

SPENDING REDUCTION PROPOSALS

THURSDAY, APRIL 2, 1981

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 9:30 a.m., in room 2221, Dirksen Senate Office Building, Hon. Robert J. Dole, presiding.

Present: Senator Dole, Senator Roth, Senator Durenberger, Senator Symms, Senator Grassley, Senator Bentsen, and Senator Bradley.

The CHAIRMAN. Let me day that we're happy to have Mr. Stockman back, the OMB Director. You are here primarily because at the last session you had to leave for another engagement and a number of Senators indicated they would like to have you back because they didn't have sufficient time to ask questions.

I hope some of those Senators will appear. But, in any event, I know you must leave no later than 11:30 and we can proceed if you wish—I assume you don't have a statement. Do you have anything you would like to say?

STATEMENT OF HON. DAVID W. STOCKMAN, DIRECTOR OF OMB

Mr. STOCKMAN. Well, Mr. Chairman, I appreciate the chance to come back. I understood this was primarily to continue the round of questioning that was——

The CHAIRMAN. A cleanup session.

Mr. STOCKMAN. A cleanup session; that's correct.

I also understand that a number of questions have been raised about certain of our proposals by witnesses who have appeared in the intervening time, and I would be very happy to try to respond to some of those statements as well.

The CHAIRMAN. Right. We operate under the early-bird theory and the first bird here this morning was Senator Roth. So, Bill, do you have any questions?

Senator ROTH. Thank you, Mr. Chairman. Yes, I do.

I was very much concerned about some of the things I read in the paper this morning. It seems to me that, again, some of the faint-hearted are beginning to raise their voices with respect to the tax cut.

Now, the thing that bothers me, this is the same old refrain that we've had the past several years. By that I mean what we're hearing again and again is that we're going to balance the budget on the backs of the American taxpayer.

Frankly, I look upon the idea of a 4-year Kemp-Roth in that vein. I would just like to call to your attention, if I might, the two charts over there. I think too many people are forgetting what's happening.

What's happening to the working people of this country is shown in these two charts.

On the right, it shows that by 1985, that if we don't do something about tax cuts, the individual income tax plus employee social security is going to go up 76 percent. And, the faint-hearted are beginning to say we should defer the individual tax cuts.

I would just like to point out, Mr. Stockman, that even if we adopt President Reagan's proposal, the Roth-Kemp tax cut, that the working people of America still face a 44 percent tax increase.

Now, it seems to me that if there is any criticism to be made about that tax cut, it's that it's not enough.

I wonder if you would care to comment?

Mr. STOCKMAN. Senator Roth, let me say first that we haven't changed our position. We believe that a 30-percent cut in a marginal rate staged in over the next 3 years is essential if we're to get the recovery and growth and expansion in our economy in which the whole program is premised.

Second, we very strongly share your view that tax reductions have to apply to individual taxpayers as well as corporations, and it seems to me that if you just examine the Federal revenue data, the tax collection data, that's pretty apparent.

If I recall the figures right, in 1982 we will collect about $70 billion from corporations in corporate profits tax. Most of the remainder of that $700 billion in revenues will be collected from individuals in one way or another; through individual income taxes, through payroll deductions. Many economists believe that the business share of the payroll tax is actually just shifted back to wages, so it's a form of personal taxation.

Excise taxes are obviously paid by individuals, and I believe very strongly that the windfall profits tax is passed forward in price and paid by individuals as well.

So, the point is, you cannot have an effective or a balanced tax reduction unless you deal with well over 80 percent of total Federal revenues that you're pointing to there in your chart, that are collected from individuals.

As I have said on many occasions, if we simply lower taxes on all the corporations chartered in Delaware and don't do anything about individuals who work for those corporations and manage them; the scientists, the production workers and everybody in between, in terms of their incentives we simply aren't going to get the kind of expansion and prosperity in our economy that we want.

Senator ROTH. I couldn't agree more strongly with you. I would just like to underscore, again, what's happening to the working people of America, which a number of people in Congress seem to be willing to overlook.

The fellow who made $15,000 or $16,000 in 1976 is going to have to earn roughly $24,000 or $25,000 today to have the same purchasing power. His taxes have gone up roughly a total of $1,400 over the last 4 years.

As I've said before, that's bad enough, but what's going to happen in the future is outrageous. If we don't turn this economy around, that guy who has a family of four is going to have to make roughly $35,000 or $36,000 to buy the same food, same shelter and same clothes, and his taxes are going to go up from $4,500 to $8,000.

I think it's important that we get home to every working family in America what's happening to them, because if we don't enact these tax cuts, there is no question that what we're doing is, in effect, voting for a major tax increase for the people of America.

I was a little bit shocked yesterday. It was April Fools' Day. A report was issued by the Joint Economic Committee, of which I am a member. Last year and the year before I was very encouraged that we had a unanimous report talking about the supply side tax cuts. The Keynesian concept has not died. Big government, big spending, has many heads.

I just wonder if you're familiar with this report of the Joint Economic Committee and would like to comment on it?

Mr. STOCKMAN. Yes, I am familiar with it and I would like to comment on it.

Essentially, that report was based on a forecast done by Data Resources, Inc. It suggested two things: One, rather than having a balanced budget in 1984, as we project and believe we can achieve, there will be a $100 billion deficit, a radical difference.

Second, rather than having inflation rates come down to the 5-percent range, they would still be embedded, as they call it, near double digits. But, instead of having interest rates come down so that people could borrow, so that small businesses could survive, so that farmers could survive and so forth, that the prime rate by 1984, even after our entire program of $100 billion worth of spending reductions, increasing tightness of monetary policy, that even after all that, the prime rate would be in the 16-percent range.

Therefore, a radically different picture was presented.

Of course, you have to ask, "Do these econometric models adequately forecast the future? What is their track record?"

I was able to get a hold of a forecast, a 3-year forecast done by this same econometric model, DRI, in 1977. And, I asked the question, "What did they forecast for 1980 and what turned out?"

What they forecasted for 1980, 3 years earlier, was a real GNP growth rate of 4.7 percent. It turned out to be negative .2.

What they forecasted for 1980, 3 years earlier, was an inflation rate of 5.4 percent. It turned out to be nearly 10.

What they forecast for the Consumer Price Index for 1980 was 5.3 percent. It turned out to be 13.5 percent in 1980.

Now, with a track record like that on the 3-year forecast, why should anybody pay attention to the numbers that they put out for 1984? It's beyond me.

So, therefore, it's an interesting forecast, but it's mostly noise, in my view, and I would hope the committee wouldn't be too disturbed or troubled by the results.

Senator ROTH. I would say, Dave, as I read what's going on here on Capitol Hill and in Washington, that Carterism is not dead, that there are still the advocates of the old economic policy, and I must say that we have a strong, new voice in President Reagan. He's the

one voice—of course, you have been a strong supporter, too, but he has been a consistent strong supporter for major tax relief for the working people, for major supply side tax cuts.

A lot of people asked me what difference I think the incident of last Tuesday makes. I can say that I think there is no factor more important in turning this country around than getting the President back in full health so that he can provide leadership. I would like to ask just one final question, if I may, Mr. Chairman.

A lot of talk has come up concerning fraud, waste and abuse in Government. As chairman of Government Affairs, we are going to be looking at some of these areas of waste and abuse. I am one that's been very concerned about travel and filmmaking. These don't seem to be the most critically important.

I would ask that you and the others look at how we can make greater savings. For example, there is something like $7, $8, $9 billion in that range, for travel, including military.

Has any thought been given that instead of requiring the military to change bases every 2 years, perhaps extending that to 3 years?

Mr. STOCKMAN. Well, that is one question that's being looked at. That is part of the travel amount. But the permanent change of station amount in that $9 billion, if I recall correctly, is only a little over $2 billion.

So, outside of that, which really has to do with management of military forces, deployment of forces and so forth, which I believe defense wants to look at, you still have about $7 billion worth of other travel, both in defense and in the civilian agencies that I believe could be reduced.

Now, we did put a 15-percent reduction in travel in force on January 20. It was one of the first acts that the President undertook in order to squeeze excessive overhead out of the Federal Government. That is still in force today and it will remain in force, with further reductions, in 1982.

Senator ROTH. I think that is a major step forward. I would like to advise you that we will be holding special hearings in the near future in these areas, as a means of making greater savings, at which time we would hope that you would be able to come and testify.

Mr. STOCKMAN. Well, I might just say on that whole range of matters: publications, filmmaking, travel, personnel, administrative overhead of questionable necessity or character; those things are hard to put in a budget in terms of something you can vote on to reduce, but they are a very important priority to this administration.

In our budget for fiscal year 1983, we have multiple billions of dollars worth of savings anticipated from a variety of initiatives in those areas, and we believe that's only the first installment; that as we get a better fix on this problem, define it more clearly, isolate it and locate it within the agencies and programs, that we can find substantially more.

Senator ROTH. Well, we look forward to working with you in these areas.

Mr. STOCKMAN. Thank you.

Senator ROTH. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. Thank you, Mr. Chairman.

Mr. Stockman, I am curious about your reaction to the new Joint Economic Committee study. The study was undertaken in response to a request that I made to the Joint Economic Committee asking that they simulate the full assumptions of the President's economic program, assuming Kemp-Roth, all the budget cuts that have been asked for as well as the unspecified ones for out years, and the money supply assumptions that have been indicated by the administration.

I had no idea what the result would be, and the result was astounding to me. Frankly, even if it was not the JEC number of over a $100 billion deficit in 1984, but the CBO number, it's considerably different than the numbers that the administration has put forward, indeed the administration's numbers are considerably different than not just the JEC numbers, but also those of Wharton, by Chase Econometrics, and Data Resources. In fact, of the major macroeconomic model, only Merrill Lynch forecasts numbers as optimistic as those of the administration.

So, I think that you have to take these things into some consideration. You can't dismiss all these studies by simply saying, "They're a lot of noise."

The assumptions governing these models are based on historical experience. The assumptions underlying the administration's, are not based on any experience. We're charting new territory.

So, I would just like to point out that I think your criticism of this is certainly logically inconsistent.

It is not enough to dismiss these forecasts by saying they have been inaccurate before. For example during and then also to say that taking the specifics, which there were a few things that happened between 1977 and 1980 that no econometric model could have factored in, things such as the Iranian Revolution, the Iraq-Iran War, food shortages. Just the price of oil went from about $11 a barrel to close to $40 a barrel.

So, I think that you can't dismiss another voice out there by simply saying it's noise if that voice arrives at a different conclusion by factoring in the same assumptions and the same numbers that you have offered.

My question to you is: In your assumption, what have you assumed about the money supply, and have you worked those assumptions through in your analysis?

Mr. STOCKMAN. The answer is: We have assumed that the money supply will grow at increasingly smaller rates along the lines projected by the Fed over the next 4 years, such that by the end of the period, the money supply, however you measure it—M1-B the monetary base, Federal Reserve credit outstanding, will be growing at roughly half the rate it is today and substantially lower than the 8 percent or so M1-B rate that we've had in the past.

Now, our difference with DRI, and I think that this is fundamental and material, is that we believe a steady reduction in the growth rate of money supply will result in a lowering of interest rates, of inflation, and of inflation expectations. DRI, essentially, assumes the opposite; that if you tighten monetary policy, that interest rates will remain very high: in the 16-percent range on the

prime. That will retard investment; that will slow down the growth of output. It's a fundamental difference as to the relationship between monetary policy, interest rates and the real economy.

The other point I would like to make here is, I brought up that record from 1977 to 1980, that forecast, to make a rather different point than I think you have implied.

The point that I was trying to make is that as big and complex and awesome as these models appear with their 800 equations, what they essentially do is extrapolate from the recent past. And, if you were making a forecast in 1975, 1976, 1977, you could very easily have seen an economy growing about 5 percent in 1980, an inflation rate of about 5 percent, and an unemployment rate at about 5½ percent, because that's precisely the condition that existed at that time.

Now, what DRI, in my view, is doing today is taking current conditions which weigh heavily into the equations out of which these forecasts are generated, and projecting them forward almost on a steady state over the next 4 years, regardless of the major policy changes that we have injected into the equation.

I disagree with that strongly because I think the economy does respond to policy, and that if we cut the growth trend of spending substantially, if we bring the deficit to a close, if we steadily reduce the rate of money supply growth, that is going to change the performance and behavior of the economy.

We can argue about the magnitude, but I think we ought to grant the premise that it will change things. My difficulty with this study in this forecast is that essentially, if you look at the numbers for 1984, they are exactly what they are today; that the policy will be fully implemented, and like a tree falling in an empty forest, it will have no impact.

I can't accept that and I have to respond fairly strongly, the way I did, in describing the results of their earlier forecasting efforts.

Senator BRADLEY. Well, what do you say to those people who look at—before I ask that I'll ask, how do you respond to people who say that you have made the assumption that fiscal policy will affect the growth by expanding it and it will also have a retarding effect on inflation. Meanwhile, monetary policy will have only a downward effect on inflation.

Why won't monetary policy also do what it has always done? When interest rates go up, economic activity falls into slack. There is unused capacity. There is higher unemployment. That's a natural response to higher interest rates.

Again, you have kind of selectively picked what the effects will be, and since you have basically dismissed any empirical evidence, and you have dismissed all of——

Mr. STOCKMAN. I don't believe so, Senator. I understand the point you are making——

Senator BRADLEY. We cannot accept the econometric model, because they only give us the recent past.

Mr. STOCKMAN. All right.

Senator BRADLEY. If we can't use the recent past as evidence, what do we use? And the answer is: We either use selected facts, since we don't use the comprehensive facts of the recent past, or we use belief; one of the two.

I think this same selectivity, I would suggest the same selectivity is used when you imply that fiscal policy will have a retarding effect on inflation and a growing effect on growth—a positive effect on growth, but monetary policy will have only a negative effect on inflation, and it will not have a negative effect on growth.

What comes first here?

Mr. STOCKMAN. Well, let me try to respond to that.

First, I would say very strongly that an econometric model is not a scientific calculating machine. It embodies a system of beliefs about relationships in the economy, including the one you are raising; the relationship between monetary policy and prices and output.

The DRI model is a Keynesian model. It believes the economy generates basicaly from the demand side.

Senator BRADLEY. Could I interrupt you? Just 1 minute.

Mr. Roberts was up here. Mr. Roberts happens to be the Assistant Secretary for Economic Policy for the Treasury Department, and I asked him directly, as I've asked most—"What is a supply side model," and he said, "There is no supply side model. Most models today include the basic assumptions about supply and demand, and if you have labeled something Keynesian, what you have done is put yourself in a historical period several years ago and you have not recognized either the change of economic theory, the evolution of economic theory, nor have you accepted the evidence of facts of the past 5 or 6 years."

Mr. STOCKMAN. So, I'll retract the label and try to make my point, nevertheless.

Senator BRADLEY. OK.

Mr. STOCKMAN. You are correct that in the very short run a sudden surge or runup in interest rates does have a retarding impact on the real side of the economy on output.

So, it may well be that we will have a soft economy in the second and third quarters due to the enormous explosion of interest rates and financial instability that we had last fall.

But, we believe that is a very temporary effect. We believe, in the longer run, the relationship reverses and that the major effect of continued monetary restraint, steadily reducing the rate of monetary growth, will be primarily on the price side as inflation expectations change and as financial markets adjust.

Now, my quarrel with this forecast is that they assume the short run relationship persists indefinitely, and that if you have a steady tightening in monetary policy over 3½ years, the major effect is on interest rates and that then feeds back into the output side, the investment side, and retards the growth.

Now, I would suggest to you that the historical record is very different. Over longer periods of time, there is a clear relationship between the level of interest rates and the level of price change or inflation and the growth rate of the money supply, however you measure it.

We believe, over a 3½-year period, what you are going to primarily get out at the end of that period is gains on the financial, price, and interest side while your fiscal policy, in terms of tax incentives, tax reduction, and regulatory relief, will be providing stimulus on the production or output side of the economy. That's a belief.

Someone is absolutely entitled to the inverse point of view.

My point, this morning, is that the DRI model largely embodies in its equations and in the interactive effects of that model the first point of view, and our economic forecast is based on the second point of view. It's a theoretical argument; it's an empirical argument, and you can go around and around a circle all day. But, that is, essentially, the difference.

But I have to stress once again, I do not buy the view, which is implicit in this forecast, that somehow inflation is embedded at 9 percent. We don't know where it came from, but it's there and it won't go away no matter what you do to change fiscal and monetary policy, and by that I mean budget policy and monetary policy, in a more sound direction.

I can't accept that premise. I can't accept that assumption, but it's implicit in this forecast and in this study outcome.

Senator BRADLEY. Mr. Chairman, I have some more, but I heard the bell.

The CHAIRMAN. Go ahead.

Senator BRADLEY. Well, what if wages and prices are sticky?

Mr. STOCKMAN. Well, that's the——

Senator BRADLEY. If wages and prices are sticky, what happens to growth then? Tight money means growth is sapped because inflation continues and you have the higher interest rates. And, what happens when you have very high interest rates? One possibility is the influx of billions of dollars from abroad, a rush that can prevent the Fed from controlling the money supplies effectively.

Have you accounted for these possibilities in your projections for budget figures and for tax figures?

Mr. STOCKMAN. Well, it is a complicated set of relationships that you are raising, but to just take them one at a time, on the sticky wage and price question, that is a hypothesis. There are some people who believe they can demonstrate that wages are sticky in that sense and they continue to rise at 8 or 9 percent and, therefore, the price level will reflect that the next year or the year after.

I don't think there is a good case for that. I would recall, for instance, in 1974 in the latter part of the year, the GNP deflator was running about 10 to 11 percent. By the end of 1976, it was running at 5 percent and heading lower. After 1976, we had a change in both fiscal and monetary policy, a very stimulative budget, if you recall, in 1977, a $30 billion stimulus program as the first initiative of the previous administration.

Then, over the course of the next 2 years, as the dollar weakened internationally, we attempted to stem that by increasing the growth of the money supply. That further built inflationary momentum into the economy, and you move back up to the plateau that you are at today.

But, it's very clear that prices and wages will adjust in response to changed policy. So the idea that they are stuck there at a certain rate that happens to exist today indefinitely, I think is wrong for two other reasons:

One, the area of——

Senator BRADLEY. Let me just interrupt you there.

Also, if you look at the unemployment rate, during the time that the GNP deflator went down, the unemployment rate was the highest it's been since the depression.

So, yes, I don't disagree that wages will go down, but they are not going to go down without pain, and I think what this study says is simply that inflation is going to go down, not as a result of "rational expectations," but as a result of a good old-fashioned recession. It's going to be occasioned by tight money, and the tight money will be precipitated by a fiscal policy that is too loose.

Now, maybe I have talked to Arthur Burns too much about this, but he certainly feels that way about it, as do a lot of other, well-respected economists in the country who see this tax cut as a form of religion to its advocates and not something based on either empirical evidence or a reasonable theory of how to produce the kind of high growth and reduced inflation that the administration expects.

Mr. Stockman. Well, Senator, there is a lot of evidence around, and I guess we all select that evidence that we think best suits the case or is most appropriate, but I don't believe there is credible, persuasive evidence that simply having a good old-fashioned deep recession will solve the inflation problem.

Great Britain is going through that wringer, and their inflation today is higher than it was when their industrial economy——

Senator Bradley. I certainly don't look at Great Britain as the example that we have to follow. But, I'm asked the question about where you factored in the stickiness of wages and prices?

Mr. Stockman. We don't believe it's been demonstrated they are sticky. You are simply asserting that, and I think you can make a strong case that they are not.

Senator Bradley. But the example that you gave to demonstrate that they are not sticky, was the 1974-76 period when wages came down. They came down, they're not sticky. That was your argument. It's true, but they came down when unemployment was the highest it's been since the depression.

Mr. Stockman. I'll give you another example.

Senator Bradley. OK.

Mr. Stockman. Throughout the course of 1976 and 1977, when the economy was expanding at 5- to 6-percent rate, unit labor costs were coming down and the price trend was favorable. It was not until late 1977, primarily in 1978 and 1979, when this current bout of inflation that we're suffering got underway.

I would suggest that there are historical observations at a whole variety of points in time which suggest that strong output growth and employment growth are fully compatible with stable or low rates of inflation. And, we can argue about how we get there and in what sequence and how policy variables work, but I hope we wouldn't rule out either alternative; that you can achieve both over a sustained period of time with the right mix of policy.

Senator Bradley. I won't rule out that alternative if you don't rule out the possibility of our study.

Mr. Stockman. I won't rule it out; I just won't accept it. I think that's——

[Laughter.]

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Senator BRADLEY. Let me move off of this—let's try to push a few angels off the head of this pin and go to another subject.

If we lost 3 to 4 million barrels of oil in the Middle East, what monetary and fiscal policy would you recommend to help us through this period? Say it wasn't a manipulated embargo, but say it was a loss due to loss of production capacity.

Mr. STOCKMAN. I would recommend no change in fiscal policy, because there would be a variety of offsetting effects which would run to the budget. If that occurred under existing policy, there would be an enormous increase in Federal revenue, primarily because of vast additional yield on the windfall tax since domestic oil prices would rise to the world level, which could be anywhere in the stratosphere that you might want to put it.

On the other hand, there would be substantial increases in outlays, because we would have to provide some kind of adjustment to people to pay their heating bills, to pay maybe even gasoline bills and so forth.

So, I would—in terms of the preexisting fundamental fiscal policy, I wouldn't change it.

Monetary policy, I think you would have to accommodate to some degree this shock, real shock to the economy, and thereby allow part of the price change for oil to be reflected in a higher level of inflation. But, I don't think it ought to be accommodated entirely or 100 percent, because then you just build in another enormous surge of money supply growth, financial instability, interest rate runup and a longer term wave of inflation that will take you a few years to dig out from under.

So, I would say modest accommodation on the monetary side; no change on the fiscal side, due to some automatic stabilizers that just by happenstance are built in to our budgeting process today.

Senator BRADLEY. What would happen to unemployment?

Mr. STOCKMAN. If there is a real shock——

Senator BRADLEY. You have said that what you would do is let inflation go, basically.

Mr. STOCKMAN. No, I did not say that. Absolutely not.

Senator BRADLEY. OK. Which would you attack first? The unemployment or the inflation? It would be occurring simultaneously.

Mr. STOCKMAN. The mix of that, unemployment and inflation, in response to this big price shock or production outage that you're talking about, will depend almost entirely on the response of the monetary authority, the Federal Reserve.

If they choose not to accommodate that price shock by increasing money supply growth, then you would feel most of the impact on employment and output. There would be a severe, sudden recession.

Senator BRADLEY. That's right.

Mr. STOCKMAN. If they chose to accommodate it partially by temporary increases in the rate of money supply growth, then you would take part of it in higher inflation; part of it in lower output.

I would like to see a partial accommodation, and you can't precisely calibrate these things, but there would have to be some accommodation on the monetary side, but not simply a validation in the sense that you create enough money to finance the economy with these huge increases in oil prices and everything else. Some of

it would have to be taken on the output or real side; otherwise, you build in a wave of inflation with all its wrenching effects throughout the economy, the financial markets and everything else that is probably more damaging than short run output and employment losses.

But, what you ought to do, I might say finally, is have mechanisms available to mitigate that oil shock and strategic storage, obviously, is one of those things that could help prevent a runup of world price suddenly, unexpectedly, with the impact that it invariably has on the economy.

Senator BRADLEY. Only a stockpile? What about a demand-restraint mechanism?

Mr. STOCKMAN. A demand-restraint mechanism?

Senator BRADLEY. Yes, I mean, you don't have rationing. You have the disruption. It's clearly in the national interest to reduce consumption of oil quickly.

What about another demand-restraint mechanism, emergency tariff or tax?

Mr. STOCKMAN. I think you almost have that built in, Senator. I think that if you had that big change—I'm not talking about something like Iran where it's a 1 or 2 or 3 million barrel-a-day net outage worldwide, but something major which I think you're talking about.

Even with the release of stockpiled oil, you would have a substantial runup in the price. There then would be a demand response to that in the economy.

To take care of people who are suddenly faced with drastically or radically higher prices for heating oil or gasoline, it seems to me a far better approach is a direct income transfer, than trying to take the price in the market, allocate the available supply, and go through all of the turmoil and dislocation that we have experienced on two occasions now, both 1979 and 1974 when we tried that route.

So deal with the income effect with income transfer policies; allow the price effects to work through the economy; maintain a steady keel on fiscal policy and modest accommodation on monetary policy; but foremostly, build up the supply as rapidly as you can during slack periods so that the overall impact that we're talking about will be mitigated in the first instance.

Senator BRADLEY. Where were you 2 days ago?

Mr. STOCKMAN. Well, the answer was: It seems to me there is more than one way to achieve an objective, and it's pretty clear to me that given the enormous budget pressure, fiscal pressure, on a whole variety of domestic programs, that we're under today because of our effort to change the direction of budget and fiscal policy, that there might well be better ways to insure financial resources available to buy oil as we move through what appears to be a glut or slack period in the world market.

We are working on those options now, and we will have them available to the Congress in a relatively short period of time.

But, the main commitment remains steady and unchanged, and that is that we must purchase at least 230,000 barrels a day in 1982, and if the market begins to work out the way some are forecasting, probably even more, and we believe you can get a

financing mechanism in place to do that without putting it in the direct budget, given its vulnerability in terms of people looking for alternative areas to cut spending.

Senator BRADLEY. Mr. Chairman, you have been more than generous with me and I will wait until another time.

The CHAIRMAN. I think maybe either Senator Bentsen or Senator Symms have questions. I indicated at the outset, I think Mr. Stockman must leave about 11:30.

I just had a couple of questions. We've given your staff a copy of our so-called Blue Book, and on page 70 we recommend a number of potential savings that would increase—make a significant savings in medicare. Just to name three, if we increased the deductible from $60 to $100, that would save about $530 million in 1982. The required insurance for home health visits, that's another $230 million, and mandatory coordination of benefits to private health insurance coverage is another $170 million.

We're going to be getting into the nitty-gritty of maybe making some adjustments in recommendations made by the administration and looking for other ways to come up with savings.

I guess what I'd like to know, if you know at this time, whether or not the administration would object to savings in these areas?

Mr. STOCKMAN. Well, Mr. Chairman, I wouldn't be in a position today to comment on any of these specific recommendations because we haven't fully evaluated them.

But, I would say, as a general matter there are two basic ways to save money under medicare. One is to accept the existing inefficient, excessively costly reimbursement system and delivery system, and require the recipients to pay a larger share of the services they receive from that system.

That's essentially what these measures do. Higher copayments, higher deductibles, higher premium contributions, and so forth.

The other approach, which takes longer to accomplish, would be to attempt to bring about changes in the delivery system and the reimbursement system in order to hold down overutilization, overtreatment, overtesting, overstaying, or the placement of people in the wrong facilities, hospitals instead of nursing homes.

You can't do that in 6 weeks or in one spring in terms of legislative action, but I think that is the only way in the long run that we really can bring this $50 billion program under control.

In the short run, there may be a few of these cost-sharing changes that could be justified under present circumstances, but I would only want to—I, personally, would see them only as an interim way of saving money on medicare until we can deal with the underlying problem, which is the cost structure and the delivery system.

But, we will evaluate each of these and try to have a response to you——

The CHAIRMAN. We would appreciate it. I'm not suggesting everybody would support those efforts, but we're going to have some difficult choices to make.

So, if you could evaluate those and give us your views in the next couple of weeks, we would appreciate it.

Another area that has been called to my attention by staff, and has been called to their attention by others, and that we are

looking at is the administration's depreciation proposal. We have also been advised that we look into the high cost of hospitalization over the years, that we have too much bed capacity.

Medicare and medicaid reimburse hospitals around $2 billion annually. Now, under depreciation costs we are told by the GAO that since they are not excluded from the administration's depreciation proposal, that could rise to $4 billion annually.

I'm wondering if that was an oversight, if you intend to exclude hospital facilities, because if we're going to phase out health planning and at the same time propose radically reducing the recovery period for depreciable real property, it's going to really almost double, according to GAO, that reimbursement expense. That's another area I would like you to look at.

Mr. STOCKMAN. We would be happy to examine that. If those facts are true, it's certainly an oversight. But, it seems to me they're a little out of the range of the possible. Most hospitals are not for-profit institutions. They are nonprofit or public hospitals or community owned.

Obviously, depreciation schedules on the corporate income tax would not apply to those hospitals. But, it wouldn't be our intent to apply the depreciation reform features of the tax program to hospitals and if that in fact is true, then I think there is some adjustment warranted in that area.

The CHAIRMAN. The staff advised me it's treated as a cost, so it doesn't make any difference about their tax status. But, anyway, this is an informal GAO report. We will try to supply more information, but it would appear that if there is some accuracy in their informal report, it's something you might want to look at. It's a rather large item.

Mr. STOCKMAN. We will.

The CHAIRMAN. Senator Symms?

Senator SYMMS. Thank you, Mr. Chairman.

Thank you, Mr. Director, for being up here. I want to compliment you for the generally good job that I think you're doing. As I told you personnally, I doubt if the administration is cutting fast enough and deep enough but, nevertheless, you are off to a good start.

I am very concerned about one thing that seems to be cropping up here in this town, and that is that there is a great deal of talk that the President's tax proposal and tax reform posture is not going to be able to pass the House of Representatives.

What kind of a negative effect will that have on this overall package if it doesn't pass?

Mr. STOCKMAN. Well, as we have said on many occasions, the four parts of this package are interrelated. The marginal rate tax reductions, the spending control plan over the next 4 years, the continued tightening of money supply growth, and the regulatory relief and reform efforts.

If one of those are dropped out of the equation, then the accumulative effects that we have projected in terms of better employment and output growth, higher real wages and living standards, lower inflation and interest, will be substantially affected, and we won't get the kind of improvement that I think the American people want.

So, without that tax component, I think we would have a far less encouraging, a far less promising economic picture in future years.

Senator SYMMS. Well, I guess what I'm getting at is: The reason I'm making it is my concern—the reason I make the statement that I think we need to cut deeper is because of the politics of—many Members of the House and Senate for their own particular reasons believe it's essential that we get spending cuts before they vote for tax rate reductions.

With that in mind, I think just the politics to get the incentive supply side tax system started, we have to have spending cuts, and I'm very, very—I'm hopeful that the administration is aware of the situation that appears to be shaping up; that we're not going to get the kind of spending cuts or tax cuts we need, and I hope that you are prepared later on this summer, when the appropriations season starts, to have the President start vetoing bills that are overspending so that we can demonstrate to the American people that we are going to control spending, so there is no excuse for anybody in this Congress not to reduce taxes on the overburdened people, because the working people in this country are paying too many taxes and, because of the way the whole package shapes down, I believe that large segments of people aren't going to participate in biting the bullet.

So, I would just leave that with you and pledge my support to encourage you to continue your efforts, because we are starting, I think, to see partisanship really become an issue in the House.

Mr. STOCKMAN. Senator, let me respond to that because I think people are underestimating what we have accomplished already, or proposed, and the Senate has largely endorsed.

Yes, for fiscal year 1982 we would save about $48 billion from the current spending base. The Senate has endorsed, over the last 3 to 4 days, almost all of those major changes in policy entitlement permanent law that would bring about those changes.

The thing that needs to be pointed out is that when you make a permanent change in entitlement or other aspect of the spending structure, those savings grow automatically without any further votes or action by the Congress in future years.

What we have accomplished thus far will grow to $67 billion by 1983 to well over $80 billion in the 1984-85 period, and to $100 billion by 1986.

Now, in addition to that first installment of permanent reductions in budgetary outlays that the Congress has responded to very favorably and the Senate has taken action on already, we have suggested we will offer $30 billion in additional cuts beyond that for the fiscal year 1983 budget, and $44 billion for fiscal year 1984.

We believe that that's achievable; that in a $700 billion budget, there are plenty of places to find 5 percent more, and that those who are worried about achieving the balanced budget in 1984, about deficits that might possibly result from the tax program, simply are underestimating the unnecessary expenditures in the budget today and, I think, the willingness of the American people and the Congress to take additional steps in the next two rounds to bring about the saving that we require.

Senator SYMMS. I appreciate that, and I just want to make it clear to you, David, that I'm not concerned about the—I'm con-

cerned about getting the tax side of this thing passed, because I think that's essential with having you achieve the other part of the goal.

Mr. STOCKMAN. Right.

Senator SYMMS. One thing I might say, and I do agree we've been successful thus far on the floor of the Senate, but you want to be sure that either Howard Baker or somebody from the administration comes over there—I see Senator Garn just came in the room, and to remind Senator Garn and Senator Dole that we need to vote yes, because we have been voting no on so many amendments on the floor and we might forget to pass the budget package.

The CHAIRMAN. Thank you. We haven't started to make a tax policy yet in the committee that has jurisdiction. I think that's something to keep in mind. There have been stories about the Budget Committee proposal, and I understand their problems. But, it would be my hope that even though they may disagree, that we'll stick with the administration's numbers—and we're not trying to do violence to the Budget Committee, but they can come up with one set of numbers that may be in conflict with the administration so far as the goal of a balanced budget for 1984. That doesn't bother me because there will be additional cuts in 1983 and 1984 that have not yet been identified.

Mr. STOCKMAN. That's correct.

The CHAIRMAN. Senator Bentsen?

Senator BENTSEN. Thank you, Mr. Chairman.

Mr. Stockman, I certainly share with you the objectives that the administration is trying to achieve, and I think that you have met with great success, as you stated on the floor of the Senate, and I certainly have seen in the aggregate the amount of cuts that you're talking about, but you're talking about a deficit of $67 billion at least, for 1982 and 1983, and I say at least because most of the estimates I see, other than the administration's, are less optimistic.

When we get to the question of the pressure on the capital markets, as I recall, you answered that by saying you would have an increase of savings that would help ease that. I think that's the real key to it.

You are projecting an increase in savings, as I recall, of about 7.5 percent by 1985, and we have only exceeded that about six times since World War II.

I would like to see us achieve that objective, because I think it's critical to us in this country, with probably the lowest rate of savings today of any major nation in the world.

I would like to try to find a common ground we could work on, if we could, toward that objective.

Is the administration just going to try to put some additional incentives, direct incentives in there for savings?

Mr. STOCKMAN. Well, Senator, we're not unalterably opposed, I can assure you of that. The real question is one of means, of technique. What is the best way to get to the common objective?

There are some who believe that we can manipulate the tax code in the right way so that we can cause income to flow toward savings and away from consumption, and there are others of us who believe that it is the high rates, especially in the upper end of the income spectrum, distribution, that's primarily responsible for

the lack of savings flow, or at least the most productive savings, in investment——

Senator BENTSEN. Let me say on that one, I helped lead the fight, I guess about 3 or 4 years ago, to try to cut investment income down to the same so-called earned income. I felt if you could have a country folk singer earn $12 million and work less than 6 months in a year and pay a maximum 50 percent tax, that that ought to be high enough, also, on so-called investment income, whether it's a savings account or dividends off of something that creates jobs.

So, I share that thought in getting it equated, equal. But, I feel that if you have some specific incentives in there for savings that you are going to increase that percentage of savings in this country, and I think you are going to have to do the extraordinary to try to get it.

Mr. STOCKMAN. Well, as I've indicated, I guess that really is a technical, practical question of what is the best way, what is the most efficient way to get it, and we are open to debate on that. I think we have the same objective.

We are not presuaded, as of the present time, however, that you can design an effective targeted savings incentive. Most of the proposals that I've seen and that Secretary Regan has looked at and the Treasury has looked at, will probably have a larger effect in terms of moving savings from an advantage—from a disadvantaged to an advantaged type of instrument or institution or deposit, rather than necessarily increasing the aggregate amount.

Now, we are not suggesting that there is no targeted savings incentive that will mainly work toward increasing the aggregate level of savings, but I think we have to be very careful about these targeted savings plans, because many of them are pushed by institutions and by industries that would receive a major shift or substitution of the existing saving going on in the economy today.

But, if it's carefully designed, you might make a strong case that that would be the desirable thing to do, but it has to be carefully designed and you don't want to clutter up the code with hundreds and hundreds of pages of regulations in order to make sure that that happens.

Senator BENTSEN. I understand that. But, we are running into a problem where we have so homogenized the financial institutions that we are resorting to arbitrage and that kind of thing to try to stay alive.

Mr. STOCKMAN. Right.

Senator BENTSEN. And we have got to find some way to try to——

Mr. STOCKMAN. Isn't that a different objective, though, Senator, to say that money markets are a bad place to save and thrifts are a good place to save and so we will give a tax break if you deposit in a thrift but we won't if you do in a money market?

Senator BENTSEN. I'm not saying that.

Mr. STOCKMAN. No, but I'm saying that the objective of that would simply be to strengthen an institution; not necessarily to raise the level of savings to finance the economy. That's the danger that I see in these proposals.

Senator BENTSEN. Well, I think we have to try to find a way, as we've seen in many other countries where they have given specific

incentives for what, in effect, turned out to be long-term money, and I would like to see us give some more attention to that and I, for one, am going to be trying to bring that about.

The CHAIRMAN. You have about 2 minutes before departure time. Maybe we can divide that between Bradley and Durenberger.

Senator BRADLEY. I'll be quick; just two questions.

A followup on your question about if there is a disruption, what fiscal monetary policies that you would follow and you said basically we have enough in place to take care of that.

Let me point out that there is no rebate mechanism in place, and that your answer doesn't address the enormous loss of wealth that would flow out of this country to pay for the foreign oil. I would hope that the administration would honor the letter that they submitted to us in the Energy Committee that there would be a statement by April 30 on the questions of supply disruptions, taxes, tariffs, and rebate mechanism, because I think that your answer has really overlooked the enormous outflow of wealth and does not take into account the need to develop a rebate mechanism to make sure that that wealth does not go all to OPEC.

My second point is, from 1965 to 1969 in this country, we expanded our defense budget considerably, and we had guns and butter. We didn't pay for it. We frequently look at that point in time as the origin of our inflationary spiral.

If you take what we spend on defense and what we increased our defense spending from 1965 to 1969, in real dollar terms the next 4 years we will be spending more on defense than we did in 1965 to 1969 in real dollars. I believe we may get into the same kind of inflationary surge now as we did then, because we are not financing that expenditure.

Mr. STOCKMAN. There are two very good reasons. One, the economy is twice as large in real terms today as it was then. Second, in the 1965-68 period, when real defense was rising, so was the domestic budget in real terms, at a rapid rate, as the Great Society was implemented.

In contrast to that, over the next 5 years the domestic side of our budget proposal would shrink in real terms, and the aggregate size of the Federal budget would decline from 23 percent of GNP to 19. That's exactly the inverse movement of the budget aggregate during the 1965-69 period that you are talking about, in which it increased from the 18 percent range, I believe, to substantially higher.

The point is, the defense path is somewhat similar, but it occurs in a much larger economy and as a share of the budget, even at the end of that period, it's much smaller; 38 percent rather than 44 percent.

But, the more important point is, the budget as a whole, under our fiscal plan, will be shrinking steadily in real terms, even with the defense increase.

Senator BRADLEY. If you take the fiscal stimulus, defense budget, tax cut, and balance those against fiscal restriction, budget cut, over this period you are $100 billion on the side of fiscal stimulus.

Mr. STOCKMAN. I don't believe that that would be accurate, even if you look at it in conventional terms. The fiscal stimulus has to

be measured by the total size of aggregate spending and the size of the deficit.

Clearly, aggregate spending growth rates are coming down drastically and the deficit is disappearing.

Senator BRADLEY. Let me just say I don't think that's the way it will work in macroecomomic terms.

The CHAIRMAN. Senator Durenberger has one question.

Senator DURENBERGER. It's a yes or no question, Dave. You know how to answer yes to a question.

Mr. STOCKMAN. Some people doubt that. [Laughter.]

Senator DURENBERGER. The National Governor's Association has been here a number of times and we have been looking at the administration's health-related recommendations and express some concern that they hadn't been involved extensively in the design of the administration's block grant.

I just wondered if you would be willing to work with us and with them in improving the recommendation? Is there room for improvement, and would you be willing to work with us in improving the recommendation?

Mr. STOCKMAN. I think the answer would be yes to both questions.

Senator DURENBERGER. Thank you very much.

The CHAIRMAN. Thank you, Mr. Stockman.

I believe Senator Moynihan and Senator Long may have also had questions, which I assume could be submitted in writing and also if Senator Bradley has additional questions.

I'm certain, before too long, you will be back, in any event, and I appreciate your coming this morning.

Thank you.

The next witness we are honored to have with us today is the Governor of the State of Utah, Governor Matheson, and we are also honored to have to introduce the Governor to the Senate Finance Committee, the senior Senator from Utah, the chairman of the Banking Committee, the Honorable J. Garn.

Senator Garn?

Senator GARN. Thank you very much, Mr. Chairman. I appreciate the opportunity of being here, and if I could take advantage of a captive microphone before I introduce our Governor, I was very interested in the conversation between Senator Bentsen and David about incentive for savings.

So, if I could spread upon the record the comments of the chairman of the Banking Committee, that I do believe that that is one area the administration or tax package has missed, is specific incentive for savings.

I know very well, after being chairman of the Banking Committee for 3 months and on that committee for 6 years the problems of the thrift industry and the problems of incentives for saving. I would agree with Mr. Stockman that there are incentives in the higher brackets for saving, but that is not addressing the problem of small savers and the masses of working people who would like an incentive to save in this country.

Last year we had the lowest rate of savings as a percentage of our total income of any of the industrialized nations far, far below it. There are a lot of so-called targeted proposals like allowing

people to save money for the downpayment on a home. And, I would say to Senator Bentsen that I do not believe that is the way to go to try and design the regulations as David Stockman is talking about, but certainly an expansion I think the Finance Committee should consider of the 200 and 200 is expanding the general savings, regardless of where you put it; whether it's in money market funds or mutual savings banks or in S. & L. banks or wherever. I think that is important if we are going to have available capital, not only for home building and providing long-term mortgage credit.

I agree with Senator Bentsen and I agree with David Stockman that we should not get into a bunch of targeted but a general incentive and tax code for small savers, I think, is imperative to solving some of these problems of the financial industry.

Excuse me for taking advantage of what I would call a captive mike, and now I will do what I was here to do. But, I couldn't resist the opportunity, after hearing that conversation.

It is an honor for me to be here to introduce Governor Scott Matheson of my State. We have been friends since both of us had hair, so that was a long time ago. We attended college together at the University of Utah, and we are fraternity brothers. We have a lot of similarities, except that he was one of the few Sigma Chi's who became a Democrat. The rest of us would rather fight than switch. We stayed loyal to the Republican Party; despite the fact of that one discrepancy in his distinguished public career of being a Democrat, I'm proud to be here to tell you that we are very proud of him in the State of Utah for his achievements as our Governor, for his work in the National Governor's Conference. He represents them well as well as our own State, and so I'm pleased that he is here to testify before you today.

I thank you very much.

The CHAIRMAN. Thank you, Senator Garn.

Your preliminary comments will be noted. We are looking for ways, and if we could figure out where to find the revenue that we would lose in increasing that exemption for interest and dividend income, I think you are correct.

Some of us have some of those targeted savings: education, housing, individual retirement accounts, and I'm not certain what the fate of those may be.

Thank you and thank you for introducing Governor Matheson. Governor, you may proceed in any way you wish. I'm certain you're accustomed to testifying and your entire statement will be made a part of the record.

I might add, at the outset, that Senator Durenberger as chairman of the Health Subcommittee, as the rest of us do, he probably has a more direct interest in many of the things you will be touching on. I think he has questions.

So, you may proceed in any way you wish.

STATEMENT OF HON. SCOTT M. MATHESON, GOVERNOR, STATE OF UTAH, SALT LAKE CITY, UTAH

Governor MATHESON. Thank you, Mr. Chairman.

I am very pleased to be here and would like to express my appreciation to Senator Garn for that very gracious introduction.

It's reached the point where I am the only statewide elected Democrat from Utah. So, we may actually be an endangered specie out there these days.

Nevertheless, my duties allow me the opportunity, occasionally, to come to Washington and, today, to represent the National Governors' Association before this committee and talk about some concerns from the State's perspective and particularly about medicaid, and briefly about unemployment insurance and also briefly about the administration's proposal to implement a number of block grants, and indicate some concerns that we have about them, although we do support the concept.

I appreciate having my testimony a part of the record. What I would like to do is simply take a few moments to summarize what is in that testimony so that we can discuss the issues in a question-and-answer format which is much more productive anyway.

We are interested in two major budget proposals before your committee: medicaid and unemployment insurance. I am here only to talk about medicaid.

The Governor who has the assignment to speak to you on unemployment insurance is Pete du Pont of Delaware who is the chairman of our Employment and Training Subcommittee of the NGA, and I would request, Senator, that the record remain open for the opportunity for NGA to submit what we think will be helpful information for the committee.

Basically, our view is that the administration's proposal on UI recipients to accept suitable work, which means any job paying the higher of the benefit, or the minimum wage after 13 weeks of benefits have been paid, and the standard which is being proposed to be set, represents a Federal standard, and where we have unique situations in the States which normally set that policy, we would prefer to see the States having the flexibility to maintain the integrity of doing it.

So, we hold a caveat about setting a Federal standard upon us in the interest of uniformity and unity, and NGA will embrace that cause fully when we present the testimony.

The CHAIRMAN. I might just interrupt there. That was the question I intended to ask when Mr. Stockman ran out of time. That will be addressed on Friday.

Governor MATHESON. I appreciate that very much.

The area in which I'd like to direct my comments, basically, is medicaid. I had the opportunity to chair a task force with the NGA. At the recent midwinter meeting, we came forward with a proposal which is basically an alternative to that, which the administration has recommended. Basically, they are proposing a 5-percent cap on the medicaid budget.

We came up with a slightly different proposal which actually, if implemented, would reduce tax dollars to a greater extent than the administration's proposal.

So, we're here, at least, with an alternative that we think is viable.

The first thing that we proposed to Secretary Schweicker was an 8-point program of change in Federal statute and Federal regulation which would allow the States managing the medicaid pro-

grams to do so from the point of view of management control and flexibility, rather than to be driven by the user of the service.

It seems that the power is in the hand of the user and not in the hand of the States as a provider. And so, the thrust of those recommendations, which I have picked off in my testimony, would allow the States to grapple with good management practice.

As one example, I might indicate to you, the matter of being a prudent purchaser of medicaid services and supplies. Currently, a medicaid client is free to choose and the State is obligated to reimburse any provider, who is qualified to give that service, and to reimburse his cost.

I am constantly in court, as Governor of my State, to try to determine what really is a reasonable cost. And so, we are requesting that that process be examined in terms of allowing the States to design a method to do a good standard with some exceptions in special cases, and not let the user drive the program. That's the thrust of that proposal.

There are several items in the testimony, and I don't think that it would be productive to tick them off, except to say that we presented them to Secretary Schweicker at our midwinter meeting, and he was gracious enough to respond to each of them. At the end of that meeting, he indicated that basically he felt comfortable with them, and in my testimony today I indicate that the administration seems to be supportive of the concepts proposed thereby.

So, we ran over to the office in the hall of the States and prepared a list of the statutes and the specific regulations we wanted to get at and delivered that to the Secretary that same afternoon, just to let him know we were serious about how we have looked at this proposal.

So, I think, perhaps, that is going forward through the administrative process, but I think it's important this committee be aware of the fact that we worked very diligently and it looks like we may be able to come up with an agreed approach on that portion of our medicaid policy.

The CHAIRMAN. Am I correct? Were there originally 10 recommendations?

Governor MATHESON. The group which I'm mentioning to you now are the eight. I think we are going to move over onto the cap issue as one of the last two, and that's where we have our basic difference of opinion about what would be a good policy to follow in the next fiscal year with respect to the capping.

We have studied that matter in some depth and reached the conclusion that the States and the Governors will oppose the 5-percent cap, but we think that in view of the fact that we have also gone on record of supporting cutbacks and balancing, and I think we're all in it together, it would be less than suitable for Governors to say no here and not come up with some alternative.

What the alternative would be is to provide a 10-percent interim limitation on medicare hospital reimbursement rates for the next fiscal year.

Incidentally, if our figures are correct, that would decrease the Federal medicare expenditure by about $1.7 billion, and taking our programs and putting the net savings below it and the administra-

tion's proposal by rejecting the 5-percent cap and using the 10-percent interim limitation on medicare, you save a lot more money.

So, we thought that that would have some attractiveness to Senator Symms, indicating his views on cutting the budget. So, I hope someone will pass that on to him.

The CHAIRMAN. Yes, the staff will pass it on to him.

Governor MATHESON. As a part of that recommendation, we also believe that we could and do support a 7-percent interim limitation on the medicaid expenditures for nursing home services for 1982. That's the area which would save about $400 million, and the reason why that makes sense to us is that is the long-term care for the institutionalized patient, often the elderly citizen, which is a predictable, manageable part of the medicaid budget.

The rest of it is victimized by what happens in the economy. One of the reasons that we are very concerned about a cap on medicaid is that the costs of that program are out of the management of the States, and if a cap goes on it, the States will be the beneficiary of responsibility absolutely without economic vitality to meet the standard.

I happen to come from a State where the cost of that particular type service has gone up 18 percent in the last year, and I was looking over some statistics about the caseload. It's gone up over 20 percent in 1980, and I'm in a depression, too. We are just being whipsawed with that proposal in terms of caseload and unmanagement cost over which we have no control, if we wish to be a part of the medicaid program.

Obviously, when you have become a part of the medicaid program—and there is only one State that has not—it is one in which commitments almost require that you maintain your service within it.

That is the basic reason we think the other approach is more advantageous. What it really comes down to to me is the medicare budget is really driving the budget in terms of inflation in hospital costs, particularly when we negotiate payment after the event, which is one of the requirements we ask you change. That is the basic part of the program that drives the medicaid up, and that's the place where we think that the control on the inflationary aspect of it would be the most advantageous.

I don't think the hospital administrators will be pleased to hear that. But, nevertheless, if you're going to have cost containment on health care, it seems to us that is the productive place to actually begin that proposal.

Finally, after fiscal year 1982, we would support a block grant authorization for the long term care portion of the medicaid program, which is the predictable, manageable caseload expected, part of the medicaid program, and we think we can manage that and have demonstrated that in the past.

Now, last and the third element of my testimony today, it's a related issue, basically, but it isn't exactly a medicaid issue.

That is the administration proposing eight new block grants which would reduce Federal aid to State and local governments. Governors like that; States like that because we foresee that if we can get the big dollars without the categorical strings, even if it's

reduced, we can still do the job and get perhaps even a better job done. I think all of us pretty much have that feeling now.

One of the concerns we have is that the proposed cut by the administration is at 25 percent. We think that we can save 10 percent.

So, there is an area that I think we al' have to let our hair down and get some good technical analysis and make certain that if the block grant is going to drop, that it ought to drop in a manageable way, but recognizing, I think, that most people are interested in going the block grant approach.

There are two problems with those block grants, even though we would support them. The first is time. We are looking at October 1, 6 months from yesterday, and most of the State legislatures have already packed up and gone home. Thank goodness in my State, but they've gone home. And so, timing on the Congress addressing whether we are going to go that route and what kind of a cut it will be priced at is basically critical to States. We are very concerned about that.

The second part of that concern is this: We can see the cuts coming. I'm not sure we see Federal standards being relaxed as a part of the cut.

All of the Governors came back here last month to find out how is this budget going to affect my State? How can I continue to manage my responsibility when I'm in a recession?

The concern we left with was that the package of cutting has to include flexibility at the same time, and so—I think Governors are very paranoid about that. I guess I'm expressing that from my personal point of view and I'm sure all of the Governors have that same perspective.

So, we need the flexibility and the standard reduced if we're going to reduce the capability to meet it by reduction in budget.

So, with those remarks, Senator, I will conclude my comments and I would be pleased to respond in any way I can.

The CHAIRMAN. I appreciate that very much.

Are you in session, your legislature in 1982? Do you have a budget session?

Governor MATHESON. I have a 30-day budget session in January of next year.

The CHAIRMAN. I don't know how many States have that.

Governor MATHESON. Almost all—the only State that meets only once every 2 years, I believe, is Nevada.

The CHAIRMAN. We appreciate what I think are good suggestions.

Governor MATHESON. Thank you very much. I'm advised by Rick here that Texas has a biennial session as well, so there are a couple of States.

The CHAIRMAN. Senator Durenberger?

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

I just want to say for the record that the chairman has certainly a much longer and deeper interest in the health care issue than I and he is to be complimented for that.

Let me start with the issue of the cap. I think the theory that was put forward for the cap in order to save money, was that it would provide incentives for the States to control medicaid costs. But, it seems pretty clear that when you're putting in close to half

the money already, it would appear that there are already pretty strong incentives at the State level to control cost. Am I correct in that assumption?

Governor MATHESON. That is certainly true from the experience I have had personally and the experience that other Governors have imparted to me.

We ended up with a budget this year which was I think—a recommended $120 million, and that budget is about one-third in our State supplied by State funds, and two-thirds by Federal, but the average State contribution is higher.

In the last 3 years, just looking at the $1 out of $3, my budgeting people have whittled and beaten that down to the point where if we can squeeze another dime out of it and I can find it, I'll take it. I think we've done that.

Then the legislature, incidentally, knocked off another $10 million off the top. So, I think our medicaid budget is about as tight as it possibly could be.

As a matter of fact, I don't think we can meet the nursing home concerns with that $10 million cutback.

Senator DURENBERGER. I think I heard your statement to say that if you got the kind of flexibility that you are looking for without a cap, that you could save at least as much or more than the administration will save with a 5-percent cap. Did I hear you correct?

Governor MATHESON. I do not have an analysis of what the eight points of flexibility would do in terms of reducing the cost, and I don't know that we've done an analysis of whether that would meet the 5-percent cap.

I don't think it would be appropriate for me to say that it would. I think you have got to kind of bet on the come on that kind of a deal and give us the chance to show you that the flexibility will in fact save money.

How much it will save I think will be substantial, but I don't think it's appropriate for me to say it would equal the 5-percent cap.

Senator DURENBERGER. Would you explain to us, briefly, why long-term care, specifically, nursing services, is acceptable to the Governors while they——

Governor MATHESON. Medicaid is a mixed bag of concerns. All of the concerns that make us reach the conclusion that we would prefer not to have a cap on medicaid are those areas of funding which are outside of the management and control of the State government. We are victimized by whatever the economic season brings us, and it's been a very bleak season, I might add to you, Senator.

So, we are not capable of predicting or managing the economics of that system and the long-term nursing care situation, however, is one in which we can predict the case load. The block grant makes more sense there.

Also, we believe that income assistance type programs of which we put the other medicaid—other than long-term nursing care in that category, is an area which we think is more appropriately managed by the Federal Government, along with other programs that fit in that category.

The States ought to do the traditional type things and pay for them and get block grants, or however we fund them, in the predictable areas such as; law enforcement, and frankly, the best example is public education where we still pay a lot of property taxes to take care of those kids and the Federal Government puts in a pretty small percentage.

So, it's within that philosophical context and that lack of control over those dollars and those other programs that drew that dividing line for us.

A good point. I have a very capable young man who has reminded me of my No. 1 priority in Utah which I've been working on, and that is alternatives to institutional care.

I have spent more time with the Department of Social Services on trying to keep people out of nursing homes than I have on all of the programs in the entire Department of Social Services, because once they are institutionalized, it's over. They are there, the expense is unbelievable, and ultimately the institutionalization, whether right or wrong, becomes a need.

So, the flexibility of alternatives is a key factor in the position we have taken because, in my opinion, we can continue to do community-based alternatives for nursing homes. I mean, we have got a pretty good track record and I'd like to get the flexibility to continue to do that, and that's the way, in my State at least, I can put some management on that cap for the long termers.

Senator DURENBERGER. I'm glad to hear you say that, but I'm going to warn you of one thing. Some television network either has or is about to do some kind of an exposé on some home health care. That will be followed immediately by the Permanent Subcommittee on Investigations and Government Affairs in which I sit investigating that.

I have a real concern that the net result of all of that is going to be to set back nationally some of the kinds of efforts that you obviously are putting forth in Utah.

Let me ask you about the issue of medicare reforms. I would be curious to know what specific reforms, other than the one that you mentioned, would have how much tax savings for medicaid or public charities and so forth. You don't have to do that today, but I think probably that's the kind of information that we are working to get from the Governors' Association anyway.

The one you did mention was a 10-percent interim limit on medicare hospital reimbursement which, I think, you said would net about $1.7 billion in savings.

But, wouldn't it also just transfer the financing of hospital care to the private need for services?

Governor MATHESON. There is a risk. I think that if we were to take and implement the eight flexible changes which I have indicated—let me just give you one example applicable to the medicare, and that's the retrospective reasonable cost hospital reimbursement policy.

Boy, that is a bad policy. And you end up negotiating the price after you've provided the service. We find out that there is no competition in the hospital business with that kind of a rule.

So, what I think—if we had that flexibility, plus the opportunity to make hospitals compete for the use under those programs, to-

gether with competitive bidding for services, I think using the results of what we're doing in our state, interestingly enough, we have a public entity which is examining cost containment policies through the whole health care field, and they keep telling us that there are driving forces such as competition, in terms of hospital payments, that can reduce your costs enormously.

Now, if you will just give us relief from that one retrospective reasonable cost negotiation, we'll show you some dramatic savings on the other side. Frankly, I think we are going to get in a little squeeze with the 10 percent, but I think that's kind of a nice place to be battling in the next year. Let's see how it works out.

I can't guarantee that we can save all of that, but I know there is a dramatic front-end capability to do that.

Senator DURENBERGER. Will that take care of the problem that I think I heard you speak to in terms of the 20-percent increase in utilization, or is it your opinion, based on your experience in Utah, with which I'm not personally familiar, that we still need for some period of time some form of utilization review, PSRO, maybe some revised form of health planning?

Governor MATHESON. I'm not sure that I can give you a good technical answer about that, Senator. I think I prefer to think about it and give you a written response.

Incidentally, I've got the NGA staff that does all this work for us, and they're pretty good. We'll get that to you.

Senator DURENBERGER. Thank you.

On the issue of the block grants, we have heard a lot of testimony in the last couple of weeks about—and I think you heard my last question to Dave Stockman about how we can change some of these blocks. Yesterday I think we spent a good part of the morning on child health care, for example.

It seems to me that you make a good case for a reduction in funding when we do consolidating or blocking, that's realistic, because we reduce too far, if 25 percent is too far and 10 percent is realistic, that extra 15 percent, in effect, puts people with needs, but who fall in different categories, either age or income, in competition with each other for these suddenly limited funds.

When that happens, they come to us and either argue against blocking or they tell us that we have to keep in place a lot of the regulatory process, a lot of the mandate that you say impede the efficient delivery of service, that add cost to the services. And so, we do that to you and we have accomplished nothing.

Would you agree with that?

Governor MATHESON. I would agree with you, and may I just give you another prespective? That of a Governor who is the recipient of the block grant, let's say with 25-percent cut from the traditional funding through the cagetorical avenue. And it is not enough to meet the minimum standard of the service which we are obligated to provide.

I can tell you, that gives Governors heartburn, because now we have to look at either dramatically reducing services, and if it's a Federal standard we can't without your help, or second, we have got to go out and raise taxes of people in our States, and that is not a very happy thing for Governors to do either.

So, we're kind of feeling like we might be getting scissored a little on that issue and, from my perspective, I hope that that will be a part of the decisionmaking process so that we all get confortable, that we want to cut back, but let's go to a point where we can still provide the services and not get singed in so doing. There is economy to be found there.

Senator DURENBERGER. Thank you.

Senator Grassley?

Senator GRASSLEY. I don't have any questions because, quite frankly, I wasn't able to be here for your testimony because of being a member of the Budget Committee and we had a hearing today as well.

I wanted to make this comment because I think that we sometimes lose the perspective of where authority has been in this country and I think, for a long period of time, throughout the development of our country, the position of Governor has been one of the most powerful positions in the country. Of course, we have seen an erosion of that as the Federal Government usurp certain authority in the last 30 or 40 years, and I think now, as I view the Government programs in the economy, there is going to be more emphasis upon the Governor's role and it's probably going to be the toughest position in the three layers of government in the next several years, particularly early on when there is an adjustment of these programs in the Federal decisionmaking to put more emphasis on their decisionmaking.

I frankly think that all of you are capable of meeting the demand, and I encourage you to only ask us for help from the standpoint of making it easy as much as we can for you. But, I think that we have tried for too long to pour this country in one mold where all the decisions were made here in Washington. We tried to solve the problems in New York and Utah the same way and I don't think we've done a very good job of it. I don't think we have been capable of it, and I think the Federal Government gives that opportunity to respond to the geographical masses of our population, to State government.

Quite frankly, just once again, assuming what our constitutional writers had in mind. I want to congratulate most of the Governors who have responded favorably to these programs and I understand that you have responded in the same way.

I want to thank you and wish you luck.

Governor MATHESON. I appreciate very much your comments. I do believe your projection of what will happen to Governors in the States in this decade, I think it's real.

I also want to see if we can invite you to come and speak to the Governors and give that same speech. I loved it.

Thank you very much.

Senator DURENBERGER. Thank you very much, Senator Grassley.

One last—two last questions. One reflected Senator Grassley's comments.

The one concern that's been expressed here of those who oppose the cap is that if we try to figure out how to do this blocking business, that we might give a State the same proportion of the total funds that are received in some base year, and that that

won't always reflect the State's current needs, the ebb and flow that's going on.

Do you see that as a problem?

Governor MATHESON. I do see it as a problem. The variation level is there across the country, but I think that we are going to have to try something on for size for 1 fiscal year and give us a chance to get enough experience to see if it's close to the mark. This is not an exact science.

I think we have got to try the—I hope we try the 10 percent on the medicare and let us see if we can do that. And, if we can't prove that we've done a good job, you can get us next year. But, I do think there is enough optimism and enough data now to indicate that it's got a reasonable chance of succeeding.

So, we are hopeful that we can decide its success by experimenting with it, and I feel pretty good about it. I would at least like to try it out for size.

Senator DURENBERGER. Let me just get you on the record with something I think you were alluding to in your oral statement and something I feel very strongly about and I've asked a number of witnesses about, and that is the idea of getting some definition now to what needs to be the future of the functional relationships between the State, Federal Government, and the local government meeting the needs of the people.

How would you feel about a proposition in which the Federal Government takes on responsibility for subsidizing the access of the disabled and so forth of the health care system? In other words, takes on medicaid, and in exchange gives the States the responsibility for, I think you mentioned education, highways is always a possibility. There is a whole raft of these programs that we are now proposing to block to the States that might be included in that kind of a swap.

Have you given that some thought and would you have some recommendations for it?

Governor MATHESON. I have thought about it a great deal, as have all the Governors with whom I have spoken. There are some absolutists who want to get into the swapping business and do it full swing. There are some who don't want to touch it, and there are several who want to try some of it on for size.

Conceptually, I think it's time to sit down and start talking about that approach and pick out a couple of areas. Again, we can't give any lead pipe cinch how successful it's going to be, but we ought to try it. We ought to be bold enough to try it on and see if it won't work.

The beauty of the system is we can tune it up later if we find that we didn't do as good a job. So, I'm certainly in tune with the concept. I guess maybe I'm not speaking for the Governors' Association. I don't know if the Governors support that. I am told NGA does support that. It's nice to know that the Governors support what I believe in occasionally.

Yes, we would want to look at that favorably, Senator.

Senator DURENBERGER. Do you find—you commented on the absolutists and so forth—do you find that those who have some concern about the slots motion come from States in which cities play a very substantial role in the financing of a variety of needs?

Governor MATHESON. You've hit into it, Senator. That's a very good place to zero in.

Senator DURENBERGER. I want to thank you very much for your testimony and for the time that you have taken. Let me just say, the association has been extremely cooperative. It wasn't just the Governors coming in here for 2 days and sitting down with Secretary Schweiker, but the association staff here has been very, very helpful to us in these hearings and in working, in effect, behind the scenes to formulate alternatives that are more realistic for everybody; not just for us who sit here and have to make decisions.

Governor MATHESON. Thank you.

[The prepared statement of Gov. Scott M. Matheson follows:]

TESTIMONY BY UTAH GOVERNOR SCOTT M. MATHESON

I am testifying here today for the National Governors' Association; I am the Association's lead Governor on health policy issues.

President Reagan's budget recommendations represent a dramatic attempt to cut government spending and to undertake a fundamental change in federal, state and local government relationships. The nation's governors support both of these broad goals, although we disagree with some aspects of the Administration's proposals.

Our views and concerns best can be understood in the context of the budget's overall impact on state and local governments. Of the $48.6 billion in fiscal year 1982 outlay savings proposed by the President, state and local grant will bear $14.6 billion, or about 30 percent, of the cuts. If enacted, the Reagan budget would reduce grants to state and local governments in real terms for the fourth consecutive year. The Administration's projections show grants to state and local governments falling from 15.8 percent of the federal budget in fiscal year 1980, to 12.4 percent in 1982, and to 9.7 percent in 1986. We estimate that federal grants would drop, as a result, from 26.3 percent of state and local spending in fiscal year 1980 to about 15 percent in fiscal year 1986.

These impacts will fall on state budgets that already are strained by the 1980 recession. As of the end of last year, 21 states were experiencing revenue shortfalls, 17 states had imposed across-the-board spending cuts (reductions ordered in Michigan were 20 percent; in Oregon, 10 percent), 14 states had imposed hiring freezes, 12 states had frozen capital projects, and 19 states had imposed a total of 28 tax increases in 1980 (10 of them motor fuel tax increases).

Despite these difficulties, the governors support the need for substantial federal budget cuts for two reasons: first, cuts are essential to combat the current inflationary psychology and to return our nation to a course of economic growth and stability; and second, the Administration has proposed a substantial increase in flexibility that would allow state and local governments to mitigate, but not eliminate, the harmful impact of the cuts.

But we also have concerns with the budget proposals, including Medicaid and Unemployment Insurance. On behalf of Governor Pete du Pont of Delaware, who is Chairman of the Employment and Training Subcommittee of the National Governors' Association, I request that the record be held open for the National Governors' Association's written testimony on the Administration's proposals concerning unemployment insurance. I also would like to mention specifically our position on the Administration's proposal to require UI recipients to accept suitable work (meaning any job paying the higher of the benefit amount or the minimum wage) after 13 weeks of benefits have been paid. The regular UI program is determined by each state's laws and financed by taxes assessed on employers and collected within each state. This proposal, and any other that determines the makeup of the basic UI program, represents a "federal standard" that infringes on each state's right to vary program components to respond to their individual social, economic, and political climate. The National Governors' Association urges this Committee to recognize the inappropriateness of such federal standards.

The budget proposal that is of the greatest concern to the nation's Governors is the recommendation regarding Medicaid. We cannot support a nationwide cap of 5 percent on federal Medicaid funding as proposed by the Administration. This undoubtedly would shift significant federal costs to many states that already are unable to afford their Medicaid programs.

As you know, many states' budgets are affected severely by Medicaid costs. The recession has caused reductions in state revenues, while Medicaid caseloads and medical care costs have risen dramatically. Our caseload in Utah has increased 20

percent during the past 11 months. This is associated with the downturn in the economy. Utilization of health care services over the same period has increased 34 percent due to the caseload increase and the Bangkok influenza epidemic that hit us and other states this past winter. Even with substantially enhanced latitude to manage their Medicaid programs, states will experience such unexpected cost increases that are beyond their control.

Three out of every five states currently are facing significant difficulties in funding the Medicaid program. Many states are finding that despite cutbacks in Medicaid, the program's cost increases are forcing reductions in state education funds and other important state responsibilities.

We want you to know that the states believe we do and will manage Medicaid costs and meet the reasonable needs of Medicaid recipients effectively within the present federal law and regulations which govern the program. If we are to do more, there must be changes in federal requirements which prevent the states from being prudent purchasers of care. We must have changes that give us more administrative flexibility.

The National Governors' Association has prepared the Medicaid Reform Recommendations I will present to you today.

We strongly recommend the following:

I. States need much greater flexibility to act as prudent purchasers of Medicaid services and supplies

There is a lack of discipline in the health care market. States are precluded by federal law from acting as prudent purchasers of care. Under current Medicaid law, clients are free to choose, and states are obligated to reimburse, any provider who is qualified to provide a covered service, regardless of cost. States must pay a hospital its "reasonable" costs—costs largely determined by the hospital itself. In addition, states are limited to two basic financing approaches: fee-for-service and a heavily regulated capitation approach. These restrictive policies increase state and federal costs. States should be given the latitude to:

(a) Restrict or preclude the participation of providers whose costs are excessive, with some specialized care exception; why must we pay the higher charges of one hospital when we can purchase the same quality care for the same service at another hospital in the same area at lower costs?

(b) Contract with physicians, hospitals, and other providers in a manner that achieves responsibility and accountability for total medical costs;

(c) Use competitive bidding and negotiated contracts for the purchase of services and devices;

(d) Adjust reimbursement rates consistent with the availability of resources;

(e) Limit reimbursement for certain complex medical procedures of a highly specialized nature—heart surgery, for example—to hospitals that have the appropriate expertise and volume; and

(f) Establish prospective hospital reimbursement rates based upon the cost of care in efficiency-run hospitals, and to establish prudent rates for hospital admissions involving frequently performed and relatively simple procedures.

II. Medicare retrospective reasonable cost hospital reimbursement policies must be replaced by prospective reimbursement policies that encourage efficiency. We should not subsidize waste

In our State and others, Medicaid purchases about one-tenth of the private medical care provided. Medicare purchases approximately 25 percent. Medicaid programs are impacted directly by Medicare full-cost retrospective reimbursement policies and contribute significantly to the current annual inflation of 20 percent in hospital costs. Medicare reimbursement policies must be revised completely if Medicaid programs and other small payers are to realize expenditure reductions.

III. States should have the latitude to enhance the role of Medicaid clients as consumers of care, and to share the savings of cost-effective care with clients in the forms of increased income, expanded benefits or extended eligibility

Existing federal regulation provisions tend to discourage rather than encourage Medicaid clients to seek care from efficient providers or to act as prudent users of Medicaid care.

IV. States need greater latitude to reduce unnecessary utilization of health care services. This should include:

(a) Wider authority to impose realistic and appropriate sanctions against recipients who willfully overutilize Medicaid services. The Utah experience has demonstrated that Medicaid recipients tend to overutilize services because the delivery and reimbursement systems stimulate increased utilization;

(b) Authority to establish utilization review programs and policies consistent with state needs and perspectives; and

(c) Nominal copayments on mandatory services for categorically eligible Medicaid recipients should be allowed. Application can be selective as to services, groups, and settings.

V. States need greater flexibility to selectively provide services where the need is greatest and/or resources will allow

Federal regulations require Medicaid programs to provide covered services to all Medicaid recipients on a statewide basis. The needs of all states vary in providing services to low-income recipients. States need flexibility to adopt reasonable eligibility and program policies to best meet client needs. We request the authority to provide certain optional services to selected diagnostic groups with the greatest need. States should have the authority to allow local political subdivisions to provide matching funds to receive federal participation for optional services and eligibility groups not covered statewide.

VI. Procedural requirements associated with fiscal penalties in the early and periodic screening, diagnosic, and treatment (EPSDT) program should be repealed

Current Federal EPSDT requirements are directed toward how the job is done, not the impact. These requirements limit States in the most efficient administration of EPSDT. Current regulations tend to penalize the States for problems beyond their control.

VII. Federal laws and regulations should be amended to allow the Secretary to waive the 50 percent medicaid/medicare enrollment mix requirment for health maintenance organizations (HMOs) in medically-underserved areas

We must be more effective in stimulating innovative health care delivery and financing. The health maintenance organization (HMO) option can assist States in reaching that goal. Existing Federal requirements tend to be counter-productive. The regulations require that clients be no more than 50 percent Medicaid and Medicare. This hampers HMO growth, particularly in areas where a large segment of the population is poor. Further, HMOs tend to stop marketing Medicaid clients and expansion when the 50 percent threshold is reached.

VIII. A maximum 90-day limit should be established for Federal approval of program changes proposed by States. There should be a 30-day limit on Federal requests for additional information. The proposed change should be approved automatically after the 90-day limit, unless disapproved specifically

We have been forced into unreasonable delays in the implementation of policy, program, or system changes because of delays in Federal-level reviews and approvals. These delays have hampered greatly the State's effectiveness in cost management and program efficiency. Utah is not alone in being put at risk in receiving Federal funding participation from the date of change.

We understand that the administration generally supports the flexibility embodied in our eight recommendations. We urge you to enact specific statutory changes to accomplish our recommendations.

The 5 percent cap on the Medicaid program is unacceptable. We believe that we have developed an alternative mechanism to achieve even greater Federal savings. Our proposals focus on hospital and nursing home costs because they constitute 75 percent of program expenditures. We recommend that Congress enact the following:

1. The Medicaid program reforms recommended by the National Governors' Association that I have described previously; States will use their new authority aggressively to reduce costs, and the Federal Government will realize, thereby, substantial savings;

2. A 10 percent interim limitation on Medicare hospital reimbursement rates fiscal year 1982 that would decrease Federal Medicare expenditures by approximately $1.7 billion; this action also would make it far more feasible for Medicaid programs to impose similar restrictions;

3(a). A 7 percent interim limitation on Federal Medicaid expenditures for nursing home services in fiscal year 1982 that would save $400 million in Federal costs; and

(b) After fiscal year 1982, a block grant authorization for the long-term care portion of the Medicaid program (appropriately indexed for inflation and each State's weighted growth in the elderly population) that allows States complete flexibility to use alternative, community-based services which maximize personal independence and minimize unnecessary institutionalization; this both would reduce Federal expenditures and provide for better and more appropriate care for Medicaid clients.

Finally, on a different but related issue, the administration is proposing eight new block grants that would reduce substantially Federal aid to State and local governments and increase flexibility in adjusting to the cuts. Our analysis shows that flexible funds, represented by revenue sharing and block grants, accounted for 16.6 percent of fiscal year 1982 State and local grants under the Carter budget, but would rise to 38 percent under the Reagan budget.

Because of the tight schedule on which the administration developed its budget recommendations, neither State and local officials nor members of the Congress have been involved extensively in the design of the administration's proposed block grants. We, therefore, view the administration's forthcoming block grant bills as a starting point. Because we jointly fund these programs with you, administer them on your behalf, and share your concern about such issues as equity, access, and protection of individual rights, we intend to work with the Congress in determining the final design of the block grants.

There are several observations that can and should be made at this point. Governors will support block grants in areas other than income assistance and medical care financing. We long have argued that such an approach would allow states not only to meet federal goals more effectively but to target their own resources, often skewed and dissipated by the categorical grant system, to meet the most pressing needs of their citizens.

The Governors have estimated the administrative savings of block grants at about 10 percent; the Administration is proposing cuts of 25 percent, not including inflation, in fiscal year 1981. There is thus little doubt that the block grants will result in reduction of services, although the extent of this reduction is difficult to estimate without specific legislation on which to base judgments.

Congress should take two major steps, apart from adjusting funding levels, to minimize service reductions. First, it should maximize flexibility and insure that the flexibility and the funding cuts arrive simultaneously. Second, it should move as quickly as possible on the block grants to insure that state and local governments will have maximum lead time for implementation.

If action on the block grants is not completed until shortly before the federal fiscal year begins next October 1, most state governments will be three months into their fiscal year without firm knowledge on how these important programs will operate. Most state legislatures will have adjourned, and will either have to be called into special session or will have to return in January to rewrite state budgets and state laws governing the operation of these programs.

Although these problems are substantial, Governors believe that the long-range benefits that block grants offer in terms of increased efficiency and healthier balance among federal, state and local government responsibilities makes tackling the block grant issue now well worth the effort. The alternative is reduced federal funding with proportionately higher overhead costs across a broad range of activities, thereby insuring that services to people bear the full brunt of the budget cuts.

Having been forced in recent months to impose substantial budget cuts themselves, the nation's Governors fully understand the serious problems now facing Congress. We are committed to work cooperatively with you in achieving the savings you desire and in minimizing the impact on the people that we represent and serve.

We appreciate the opportunity to present the specific views and recommendations of the National Governors' Association concerning Medicaid reform and an overview of the states' perspective on block grants. The states and federal government are at a critical crossroads in providing medical services to a large segment of our nation's population. We commit our cooperation and willingness as states to work as partners with the Administration and Congress in resolving the great problems of meeting the recognized needs of the disadvantaged in our nation and doing so in the context of reduced state and federal resources. It will require imagination, creativity, and skill on the part of all concerned.

Thank you.

Senator DURENBERGER. I think the hearing is adjourned.

[Whereupon, at 12:14 p.m., the hearing adjourned, subject to the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

THE AMERICAN ASSOCIATION OF NEPHROLOGY NURSES AND TECHNICIANS, COMMENTS FOR THE RECORD, REGARDING PROPOSED BUDGET CUTS TO THE MEDICARE/ESRD PROGRAM

Mr. Chairman, members of the committee, our Association is a four-thousand member group of Registered Nurses, Licensed Practical Nurses, and Dialysis Technicians involved in the delivery of hands-on care to the end-stage renal disease patients in all areas of nephrology (renal) care: conservative management, hemodialysis, peritoneal dialysis, and transplantation. This includes, of course, both adult and pediatric.

Our Association has three major areas of concern. They are: (1) The effect of elimination of Networks; (2) the effect of a single rate reimbursement for out-patient dialysis; (3) the effect of lengthening the time between, or eliminating altogether, the State Agency survey process for dialysis/transplant units.

ELIMINATION OF NETWORKS

It is generally agreed among many groups of providers that the ESRD Networks have not been totally effective in their mission. It is also generally agreed that the vital component of Network operations that must be preserved is that of data collection. It is unfortunate that it was not until 1980 that the Networks finally began to make some impact on the local dialysis/transplant units compliance with the annual request for data.

Another good result of Network operations was that it did set up a communications system between dialysis/transplant units, between dialysis/transplant professionals (nurses, physicians, technicians, social workers, dietitians, etc.) and in some Networks, between dialysis/transplant patients. Observing interactions between other professionals in working through planning activities and review activities has been a learning experience for all involved.

We are generally hopeful, that if these activities are given to the individual States to administer, there may be less chaos than at present. We are aware that Michigan and New York State are presently searching for other funding to keep their Network activities going on a more volunteer basis rather than through regulations. This may be appropriate, but there will still be a need for a national clearinghouse for all information to sift through. A single reimbursement center or intermediary has also been suggested for all ESRD billing. These ideas both make sense. Some method of regional implementation is also possible.

SINGLE RATE REIMBURSEMENT FOR OUT-PATIENT DIALYSIS

Our major concern in moving to a single rate of reimbursement (possibly $125.00/treatment, instead of the present $138.00) is that the number of professional nursing personnel will be drastically reduced to help maintain the present operational costs. This is a very serious issue in terms of patient outcomes and general level of functioning among dialysis patients who have the advantage of all Registered Nurse staffing versus those units, which for cost saving reasons, rely almost entirely on inadequately prepared technical assistance. We would suggest that some research money be allocated for study of the nature of the difference between these two different delivery systems.

Our Association has had Standards of Clinical Practice for the care of the nephrology patient since 1974. The ESRD patients have altered physiological status, altered psychological status, as well as increased learning needs, as a result of their renal condition. These professional Registered Nurses on dialysis/transplant units are prepared to assist patients and their families in adapting to their situation according to their strengths.

STATE AGENCY SURVEYS FOR MEDICARE CERTIFICATION

It is generally felt the survey process as presently conducted in dialysis/transplant units is not sufficient. However, if this process is eliminated those only marginally safe units will become even more unsafe. It has been suggested that this part of the budget cut not be implemented until the effects of the previous two areas be evaluated.

Our suggestion is that an across-the-board peer review system be implemented for dialysis units, with separate components, of course, for all the professionals involved in the delivery of ESRD patient care; nurses, physicians, technicians, social workers, dietitians, etc. Each group implement their own review mechanism to insure competency of its practitioners. As previously stated, our Association has Standards of Practice from which a system of peer review could be developed. By implementing a systematic, deliberate mechanism for peer review, the gaps in knowledge or per-

formance could be identified, and attempts made to rectify them before any harmful omissions occurred in patient care.

ADDITIONAL ISSUES OF CONCERN

1. It has been suggested that all potential renal dialysis patients be evaluated for home dialysis training (either hemodialysis or peritoneal dialysis) and transplantation before they embark on a long-term course of in-center dialysis. Only those patients who have been justifiably evaluated as unsuitable for one of the other two options, would be directed to participate in a long-term, in-center dialysis program. The treatment of choice, therefore, would be home training or transplantation.

2. *Disability.*—There has been an unfortunate misinterpretation of the term disability. Our goal is to rehabilitate these patients as fully as possible. However, our labelling of the patients and our treating them as disabled individuals has, in many cases, hindered their efforts to lead a useful life around their dialysis treatments. The whole aspect of rehabilitation needs careful scrutiny immediately.

3. *Reuse.*—Until the U.S. Food and Drug Administration, the American Association for Medical Instrumentation, and the National Center for Health Care Technology develop standards for reuse methodology, we suggest that the patients be informed of the use of reuse procedures and sign a consent form.

4. *Transplants.*—It is unfortunate that at the present time there is not much in the way of facilitating the process for the patient wishing to explore the process of obtaining a transplant. Work needs to be done in that area. In addition, continued funding needs to be appropriated for additional research into successful transplantation.

Thank you for the opportunity to comment on these proposed budget cuts to the Medicare/ESRD program. We are available at any time to assist you with your questions.

STATEMENT BY AMERICAN ASSOCIATION FOR RESPIRATORY THERAPY

The American Association of Respiratory Therapy welcomes the opportunity to comment on certain provisions of the Reagan Administration to modify the Medicare program through the budgetary process. The AART is a professional association based in Dallas, Texas, representing close to 20,000 respiratory therapy professionals across the country.

Of particular interest to the AART is the proposal to repeal Section 933 of Public Law 96-499, the Budget Reconciliation Act of 1980. The section establishes comprehensive outpatient rehabilitation services as a reimbursable component of the Medicare program. And while the Administration has tacked a $13 million price tag onto this program, that figure is terribly misleading. This statute does not authorize any NEW medicare benefit. It merely takes certain Medicare benefits currently paid to hospital outpatient departments and encourages the establishment of free standing health care facilities to deliver those same benefits. Importantly, there is no computation of reduced institutional costs in the $13 million figure, and the AART firmly believes that such reductions may more than cover any potential cost increases.

There is another issue at hand here that is more important to the AART. There appears to be a movement to reduce the size of the Medicare benefit package without consideration of the possibility to modify the administrative side of the Medicare program. Rather, a meat ax approach to benefits is suggested. We believe that many areas of the Medicare program can be fine tuned to result in significant savings, more than offsetting any possible cost implied by this legislation. We have attached a basic shopping list of proposals which affect the administration of Medicare but do not affect the benefit package. We would hope you would see that hundreds of millions of dollars can be saved, and the actual services to beneficiaries will not be diminished at all. We strongly support any movement of the Congress to take such administrative actions rather than to make an unwarranted repeal of benefits already being administered by the government. Ironically, it seems much wiser politically to keep the benefit package intact and to improve the Administration of the program. We hope that you will act this way.

Home Health deductible: Under current Medicare policy there is no deductible for home health benefits under Part B. Establishment of a $10 or $20 deductible, either per year or per episode, would result in savings.

Physician Fee Schedules: The formula by which Medicare increases reimbursement to physicians could be modified. Time spans between each revision could be lengthened, and the indexing formula which takes various economic indicators into consideration could be changed.

Competitive bids: The degree to which Medicare seeks competitive bids with intermediaries and carriers ought to be expanded. This would result in cost savings as well as more incentives by the intermediaries and carriers to manage effectively.

Determining reasonable charge: Current Medicare policy utilizes more than 200 localities in determining reasonable charge for physicians. It would be possible to establish statewide median charges, in addition to prevailing local charges. To the extent that any prevailing charge in a locality was more than 25 percent higher than the statewide median, it would *not* be automatically increased every year.

Consolidation of Medicare inspections: Currently Medicare inspects and certifies hospitals, nursing homes, home health agencies, laboratories, and other providers. Better coordination of these duplicative processes should reduce costs.

Percentage contracts: All provider contracts for services under arrangements should expressly prohibit percentage basis reimbursement.

Reimbursement for durable medical equipment: Reasonable charge for DME should be calculated on a prospective basis and will take into account, in addition to customary charges, the acquisition costs, appropriate overhead, and a reasonable margin of profit.

Home health agency limits: No home health agency should be permitted to maintain a patient load exceeding 85 percent Medicare beneficiaries. Currently many home health agencies, known as 100 percenters, handle only Medicare patients and, because of a quirk in the reimbursement formula, are able to escalate charges unreasonably.

Medicare coverage for the working elderly: Make Medicare the payor of last resort for the working aged.

Hospital purchasing practices: For most frequently purchased supplies, establish maximum allowable costs essentially based on median prices at which those items may be procured in given quantities. Costs in excess of allowable amounts would not be reimbursed.

Elimination or reduction of return on equity capital of proprietary providers: Proprietary providers are, in addition to compensation for other costs, allowed a return on equity capital. Nonprofit providers are not. While the rationale for this distinction is based on the theory that nonprofit providers have received significant Federal assistance while proprietary providers have not, Federal programs for construction of hospital facilties and other health care institutions have been terminated or sharply reduced. This distinction is now questionable under present economic circumstances.

If the return is not eliminated, it should be reduced to a level no greater than the cost of money to the U.S. Treasury. This would save one-third of the payments now being made.

Statement of the Alliance of Metalworking Industries

The Alliance of Metalworking Industries is composed of six national metalworking associations who together represent 20,000 manufacturing plants employing 880,000 individuals with combined annual sales of over $34 billion. The six member associations are the American Metal Stamping Association, the Forging Industry Association, the Metal Treating Institute, the National Screw Machine Products Association, the National Tooling & Machining Association, and the Spring Manufacturers Institute.

The industries represented by AMI consist principally of independently owned and operated contract manufacturers of component parts, produced to consumer specification. While some companies produce end products and/or catalogue items, most companies are suppliers to a wide variety of manufacturers whose products are found in practically every market in this country.

Major customers include industries such as aerospace, defense, automotive, appliance, construction equipment, energy, electronics, agrcultural equipment, nuclear, transportation, and recreation.

Member companies average 46 employees per plant and $1.8 million in annual sales. Thus, the typical company can be truly considered as a small business. Together, these small businesses represent a far-reaching influence on the manufacturing capability of the country, and have a major impact on this Nation's economy.

Mr. Chairman and members of this committee, to emphasize the commitment of our industries to the entirety of the President's economic program, AMI would like to include in the hearing record the following resolution. This resolution was unanimously adopted on March 11, 1981, by the 220 chief executives of small metalworking companies who attended AMI's sixth annual Washington conference.

This resolution sincerely expresses the sense of urgency with which the members of the Alliance of Metalworking Industries implore the Congress to act favorably on the President's program for economic recovery for our country.

ALLIANCE OF METALWORKING INDUSTRIES, RESOLUTION IN SUPPORT OF THE REAGAN ADMINISTRATION ECONOMIC PROGRAM, MARCH 11, 1981

Whereas the growth of the federal government, increased deficit spending, and excessive taxation have led the United States to the brink of economic calamity, and

Whereas the American people have expressed their will, in the November 1980 elections, to have the scope and costs of government vastly reduced, and

Whereas President Reagan has proposed a comprehensive program to reduce the growth of government spending and the proliferation of federal regulations, coupled with individual and business tax reductions, and

Whereas immediate action by the Congress is necessary to deal with this situation;

Therefore be it resolved, That the Executive Council and Members of the Alliance of Metalworking Industries endorses, in total, President Reagan's economic program; and

Be it further resolved, That the Alliance of Metalworking Industries urges immediate Congressional approval of this economic program.

TESTIMONY OF THE AMERICAN COLLEGE OF CARDIOLOGY, SUBMITTED BY DAN G. MCNAMARA, M.D., F.A.C.C., PRESIDENT

Mr. Chairman and members of the committee, I am Dr. Dan G. McNamara, Professor of Pediatrics and Chief of the Cardiology Section, Baylor College of Medicine and Texas Childrens Hospital in Houston. I am also President of the American College of Cardiology, a professional medical specialty society with membership numbering just over 11,000 physicians, scientists, and educators who specialize in diseases of the heart and circulatory system. It is in this latter capacity that I submit this testimony for inclusion in the formal hearing record.

The purpose of this testimony is to express our opposition to the Administration's proposal to repeal the Maternal and Child Health and Crippled Children's Services Act (Title V of the Social Security Act), and to replace these vital programs with an unrestricted health services block grant.

As a pediatric cardiologist, I spend a good portion of my time diagnosing and treating children afflicted with crippling heart disorders such as congenital and rheumatic heart diseases. With our current knowledge of the causes of coronary heart disease in the adult, I am convinced that our chances to reduce the prevalence of this type of cardiovascular disease is highest when our prevention efforts include, if not focus on, children. In fact, as I noted in my convocation remarks presented to the American College of Cardiology at its Annual Scientific Session last month, "The pediatric oriented message that you will hear in the coming year is as follows: (1) the time has come for physicians, parents, school teachers, lawmakers-all-to act upon the knowledge that both coronary heart disease and hypertension start in childhood and (2) the acquired habits that aggravate, if not initiate, these diseases are learned from adult models during the impressionable period from infancy through early adulthood." I can only reiterate this here by urging the Members of this Committee to look carefully at how far we have come under current law in terms of improving child health, and to consider how substantial the setback might be if we risk this progress by repealing Title V.

For over 45 years, the Title V programs have played a key role in furthering the national commitment to improving the health of our infants, children, and pregnant mothers. The relatively small amounts of money committed to the states have had an enormous impact on reducing infant mortality and morbidity. Title V services place a heavy emphasis on prevention, and the program has been highly successful in turning scores of children into productive adults rather than dependent charges upon society because of these services. The program has proved that there is no more cost-effective use of monies than on the health of our children.

Of particular concern and interest to the American College of Cardiology is the Crippled Children's Programs under Title V, which currently constitute the major nationwide health care delivery system providing services to handicapped children. Under Title V, each state has organized a crippled children's services agency for locating, diagnosing, treating, and hospitalizing children who are crippled or suffer from conditions which will lead to crippling. Currently, every state has chosen to use these funds to cover cardiac services for children who otherwise would not

receive health treatment because of lack of access to adequate health care for geographic or other reasons.

The repeal of Title V as proposed in block grant legislation would have a severe impact on the capabilities of states to serve the needs of crippled children. States will no longer be required to maintain a special agency for crippled children or to "match" Federal grant funds, thus diminishing public health resources available for these children while compromising the whole system of services for handicapped children. Additionally, the diminished or non-existent Federal presence as a result of the repeal of Title V will reduce the Nation's capability to assure health services to crippled children. The Federal Government would no longer have the ability to provide technical assistance and consultation to the states regarding the needs of handicapped children, nor would it be able to support the applied and clinical research or the training of health care professionals that are so important to improving the services to handicapped children. Moreover, crippled children and their families are probably the least able to compete effectively with other groups affected by the block grant. All of these factors combine to severely limit the level of services that will be available to crippled children.

Let me illustrate this point from my vantage point as a pediatric cardiologist. Title V crippled children's funds have been used to support regional cardiac centers. These centers provide cardiac services to children with complicated cardiac conditions and to those from states with inadequate cardiac facilities of the own. This longstanding and successful system of coordinated services and regionalized care for children with heart disease will be wasted, because the states will not have the resources to continue this effort on their own.

The American College of Cardiology supports the Administration's efforts in reducing Federal costs, but we believe that the proposed reduction in funding levels for the Title V programs will defeat the intent of Congress to meet the needs of our country's children. Accordingly, we recommend that current Title V authorities be funded at levels of $411 million, which represents no increase over the fiscal year 1981 appropriation levels. Also, the College supports this Committee's efforts to modify the Title V programs in ways which will increase the overall effectiveness and efficiency of Federally subsidized child health services. For instance, Title V may provide a good vehicle for the consolidation of various smaller categorical child health programs to alleviate the problems of fragmentation and duplication of services.

In summary, the Administration's proposal to create a large unrestricted block grant to the states for basic health services represents a marked and potentially devastating, departure from the long-established and successful Federal policy to protect and to provide for needed cardiac care and treatment services for a very vulnerable section of the population. Given the proper medical and surgical care, fully 85 percent of the 26,000 children born each year with serious congenital heart disease can reach adult life and contribute to society and to the gross national product. To merge the activities currently conducted under Title V with other programs would place the health care status of our infants, our crippled children, and our pregnant mothers in jeopardy. We cannot afford to take that risk.

Accordingly, The American College of Cardiology supports the continued retention of the Title V health programs, at current funding levels, with such modifications as will increase their cost-effectiveness and efficiency.

Thank you for providing the American College of Cardiology with an opportunity to present our views on this important matter. If I, in an individual capacity, or the College, can be of further assistance to this Committee in these vital deliberations, please let us know.

Statement of the American Dental Association on the Dental Consequences of the Administration's Spending Reduction Proposals

Mr. Chairman and members of the committee; I am Dr. James P. Kerrigan of Washington, D.C. I am a member of the Council on Legislation of the American Dental Association which I am representing today.

We are pleased to have the opportunity to outline the concerns of the Association with the potential impact of two of the budget proposals offered by the Administration.

With respect to the proposed repeal of the dental amendments recently included in P.L. 96-499, we are attaching a separate statement and endorse the position stated by the American Association of Oral and Maxillofacial Surgeons. Those amendments to correct basic inequities in the Medicare program were adopted after several years of consideration by Congress. Their cost is inconsequential and they should be retained.

Our second concern is with the potential consequences of placing a cap on federal contributions to the Medicaid program. The Association has long-standing policy favoring "the inclusion of dental care benefits for all persons eligible under Medicaid." The policy stems from the Association's belief that dental care is an integral part of total health care and that indigent persons should have equal access with the rest of the population to needed dental care services.

While we have not yet had the opportunity to see the actual legislation which will be introduced on behalf of the Administration, we are concerned over the effect that an abrupt shift of Medicaid financial responsibility might have. If experience can be used as a guide, the states might be expected to reduce or eliminate the adult dental programs that now exist. Many of these programs even now are inadequate.

Medicaid's early and periodic screening, diagnosis and treatment program requires that dental benefits be provided to children of Medicaid eligible families. This mandate is important in attempting to assure that these children receive the dental care necessary to help form a basis of good oral health. We believe this same mandate should apply for all Medicaid eligible individuals.

We also view with concern reports that the Administration is willing to adopt a policy which would limit individual freedom of choice of provider under the Medicaid program. We think the elimination of the freedom of choice concept can result in a second level of health care for individuals who are eligible for Medicaid. Freedom of choice is basic to the health care delivery system. An individual should be able to receive his health care services where he desires.

We understand that the status of the economy makes difficult decisions necessary. Our commitment is to assuring the availability or proper dental care for Medicaid eligible individuals. We believe it is important that we point out to you the effect which this proposal could have on the dental health of the more than 7 million needy adults who are eligible for Medicaid benefits.

I would be pleased to try to answer any questions you or the other members of the Committee may have.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION ON THE PROPOSAL TO REPEAL PROVISIONS OF PUBLIC LAW 96-499, CORRECTING INEQUITIES IN MEDICARE, MARCH 31, 1981

The Association appreciates the opportunity to present its views to the Committee, but in all candor we regret that it is necessary to comment on a proposal to repeal certain amendments to the Medicare law that have been extensively considered and acted upon by the Finance Committee and Senate on several prior occasions.

Briefly stated, the amendments that have been targeted for repeal were designed simply to eliminate some long-standing inequities by clarifying the law so that an aged beneficiary would not be denied a benefit (1) where a dentist, acting within the scope of his license and training, performed a service that would be reimbursed if performed by a physician or (2) where hospital expenses necessitated by the severity of a dental condition are incurred.

We thought that when the above amendments were included in Public Law 96-499 just a few months ago the problem had finally been laid to rest. Instead, with the ink barely dry on that law, we are confronted with a recommendation that the amendments be repealed (and the inequities continued) because they are of "low priority".

We respectfully submit, Mr. Chairman, that while the continuation of the inequities may be considered by some to be of low priority because of the small number of Medicare beneficiaries who would be affected, they are of high priority to those few elderly persons who find that reimbursement for a covered service has been denied because a dentist rather than a physician performed the service. Likewise, it is a matter of high priority to those elderly persons who find out after the fact that hospital expenses necessitated by the severity of a dental condition do not qualify for reimbursement.

These are the inequities that last year's amendments were designed to remedy. It could be argued, which we have done on numerous occasions, that the amendments would not have been necessary had the Medicare administrators made a reasonable interpretation of prior law. We have not found any evidence that it ever was the intent of Congress to deny a covered benefit simply because the site of a severe condition is in the oral, maxillofacial region and an aged beneficiary elects to have treatment given by a duly licensed and qualified dentist who has full hosptial privileges and the same accountability as his physician colleagues. The same is true of the limited and circumscribed instances where the severity of a dental procedure itself, when combined with the overall condition of a particular patient, requires

hospitalization for the safe performance of the procedure and the proper management and control of the patient.

Mr. Chairman, we hope you would agree that the amendments cannot realistically be viewed as providing for "expanded Medicare coverage" when their whole intent and purpose is to give clear direction to the administrators and at the same time eliminate a discriminatory and arbitrary denial of benefits at minimal, if any, additional cost to the government.

In this latter connection, we challenge the cost estimates that have been given to this Committee by the Department of Health and Human Services. We emphatically do not agree that an amendment recognizing the right of a dental practitioner to provide *already* covered services can have a noticeable impact on Medicare expenditures. Nor do we agree that legitimate hospital expenses for severe oral conditions should be set apart.

To put this aspect of the matter in further perspective we would point out that the exclusionary language in Section 1862(a)(12) of the law remains so broad that the amendments we are discussing cannot reasonably be considered as significantly expanding benefits or increasing costs.

Mr. Chairman, the American Dental Association is sympathetic with many of the efforts that are being made to contain federal expenditures but we do not believe the correction of the inequities we have described can properly be placed in this category. In the interest of fairness and administrative clarity, we strongly urge that the Committee stand behind its recent action and reject the recommendation to repeal the amendments.

Statement of the American Occupational Therapy Association, Inc. on Proposed Budget Cuts Affecting the Medicare Program

The American Occupational Therapy Association, Inc. (AOTA) appreciates the opportunity to submit this testimony in conjunction with the Committee's hearings on the Administration's budget proposals.

With the enactment of the Omnibus Reconciliation Act (P.L. 96-499) last December, several important changes in the Medicare law were finally accomplished. Many of these changes had for several years been the subject of serious congressional discussion and debate. Their adoption marked the end of a well considered and conscientious effort to improve the quality of care supported under the Medicare program in as cost-effective and reasonable fashion as possible. The current Administration has now requested that this congressional decision, reached after years of thoughtful consideration, be suddenly reversed barely four months after its adoption. The Association urges the Committee to reject this Administration request.

Two of the proposals enacted in P.L. 96-499 affect occupational therapy directly. One of these permits coverage of occupational therapy as a primary or qualifying home health service. The other establishes comprehensive outpatient rehabilitation facilities as Medicare providers. Occupational therapy is among the services usually furnished in such facilities. By reducing barriers to the provision of service in less costly outpatient settings, both of these provisions represent an important cost-effective step towards shifting the primary focus of Medicare coverage away from institutional care.

With regard to the second of these provisions, that affecting comprehensive outpatient rehabilitation facilities, the Association joins in support of the testimony submitted by the National Easter Seal Society and the National Association of Rehabilitation Facilities in conjunction with these hearings. There is no reasonable justification for the failure to permit coverage for these facilities. This is especially true in light of the fact that the services furnished in these facilities are covered when provided on an outpatient basis by a hospital. Whether the setting is the hospital outpatient clinic or the comprehensive outpatient rehabilitation facility, the same service is provided under the same coverage criteria to a patient with the same level of medical need. Before enactment of P.L. 96-499, however, only the hospital qualified for reimbursement. Now that this unnecessary and wasteful distinction has been removed, it should so remain and the provisions of P.L. 96-499 should be left intact.

The provision in P.L. 96-499 establishing occupational therapy as a primary home health service should likewise remain in the law. The remainder of the Association's statement will focus on this issue.

Occupational therapy is a health profession which has its foundation in the medical management of patients. The service is provided to persons of all ages who are physically, psychologically, or developmentally disabled. It includes the functional evaluation and treatment of several different types of patients including those suffering from strokes, heart attacks, arthritis, diabetes, serious burns, spinal cord

injuries, and psychiatric disorders. The purpose of occupational therapy is to direct these patients to achieve a maximum level of independent living by developing those capacities which remain after disease, accident, or deformity.

Besides the home setting, occupational therapists provide services in rehabilitation centers, in acute care hospitals, long and short-term psychiatric facilities, skilled nursing facilities, outpatient clinics, community mental health centers, tuberculosis hospitals, day care centers, and private and public school systems.

For many patients, the continuation at home of the specific occupational therapy program begun in the hospital or other inpatient setting is a critical factor in their full recovery or the prevention of further disability. A patient who has suffered a stroke and has residual paralysis in his arm needs a home-based occupational therapy program of remedial tasks to increase range of motion and maximize muscle tone, to encourage sensory integration and coordination, and to decrease painful debilitating contracture. The occupational therapist may also design or prescribe assistive devices to allow purposeful movement.

An occupational therapist is also needed to train the patient in essential activities of daily living, such as feeding, dressing and personal hygiene, and to teach the patient safety techniques to avoid accidental injury. Patients with sensory loss may bump into objects and sustain fractures, or burn themselves with household appliances. Patients with visual perceptual loss (such as a loss of vision in one half of the visual field) may fall out of bed or off a commode, or walk into a wall and severely injure themselves.

Occupational therapy is also essential treatment for a homehold patient with severe arthritis. An occupational therapy home program would include instructing the patient in manual tasks to improve joint mobility and muscle strength and decrease the affects of degenerative joint disease, so as to sustain the patient's ability to perform the crucial tasks of daily living. The occupational therapist would also teach energy conservation and joint protection and provide instruction in the use of assistive devices to minimize the stress on joints and develop independence. Instruction in methods of protecting joints will help keep the patient independent by inhibiting further deformity, and reducing the need for rehospitalization or corrective surgery.

Occupational therapy may be the only service required for the stroke and arthritic patients described above, as well as for other diagnosed conditions, at the time when the treatment program can be safely shifted from the hospital to the home. At this time the physician prescribed treatment plan will still be in process. Completion of this program through the provision of occupational therapy in the home setting will ensure continuation of the functional improvement begun in the hospital. Without such follow-up the patient's rehabilitation would regress and the value of the time and money expended on the provision of the inpatient services would be greatly diminished.

Occupational therapy is also frequently required to reduce the need for institutional care. If a person is living at home with a diagnosed condition which is prone to deterioration, therefore increasing the possibility of the need for institutional care, home care service provided by the occupational therapist can frequently eliminate, or certainly delay, the onset of such need.

For example, older persons with rheumatoid arthritis, a progressive degenerative disease affecting the joints and surrounding tissues, are often hospitalized because they can no longer care for themselves. Loss of a few degrees of motion or flare-up in just one joint can cause a rheumatoid patient suddenly to become dependent. In many cases an occupational therapist can come into the home and assess these patients to determine whether new techniques need be learned to accomplish proper self care or whether new equipment is necessary. When access to occupational therapy in the home setting is afforded, hospitalization need not be the only option available for proper treatment of such patients.

When the Medicare law was revised to permit coverage for occupational therapy as a primary home health service, Medicare beneficiaries were given improved access to a form of care which is more appropriate, humane, and productive.

Home care is more appropriate because it is more reality oriented than care provided in an institution. The home is the primary place where the patient must successfully adapt the treatment received in the hospital to the daily life environment. The sooner the individual's rehabilitative program can be implemented within the home setting, the better will be the chances for the success of that program.

Home care is also frequently more appropriate because many individuals are simply unable to travel to outpatient treatment facilities. The nature of the individual's condition, the absence of suitable means of transportation, or even certain

weather conditions, all can serve to reduce the person's access to care outside the home.

Home care is more humane precisely because the individual is psychologically more comfortable in the familiar setting which the home affords. The disorientation and insecurity which frequently result when a person is transferred into an institution can be avoided when care is provided at home. Individuals are, therefore, better able to learn the compensatory skills required to make them as independent as possible within the limits which their sickness or illness has imposed.

In general, then, home care is more productive. The personal and environmental factors involved in the treatment of persons at home effectively complement the actual provision of service in a manner which greatly increases the chances of successful rehabilitation.

Of special importance in this regard is the effect which institutional care can exert on the person's sense of independence. The routine of institutional care frequently fosters a sense of dependency which can significantly undermine the progress of rehabilitation. Rehabilitation requires the patient's active involvement. Even during a relatively brief institutional stay, the unfamiliar setting, particularly with elderly persons, can produce confusion and disorientation which interferes with their progress toward independence in daily life activities such as eating, dressing, and bathing. To resolve these confusion problems, patients will frequently rely to an unneccessary degree upon the supports which the institution provides. Their motivitation to learn the adaptive skills needed to increase their independence will diminish and their rehabilitation will be slowed, if not delayed indefinitely. Proper and timely care in the home setting offers a greater opportunity for maintaining that degree of initiative required to make rehabilitation productive.

The Association believes, therefore, that the establishment of occupational therapy as a primary home health service represents a significant and reasonable improvement in the Medicare program. This change removes an unnecessary barrier to the provision of quality and cost-effective care. The Association also realizes the Committee's serious concern for cost savings. The remainder of this statement, therefore, will address this issue of cost as it relates to the occupational therapy home health provision.

In general, the Association believes that the initial cost estimates assigned to this proposal are inaccurate, primarily because there are not, nor will be in any immediate future, sufficient numbers of occupational therapists available to provide the quantity of service which would support such estimates. The Association further believes that no consideration has been given to the cost savings which will result from reduced institutional care or reduced utilization of other services. Finally, the Association believes that removal of this arbitrary barrier to access to home care represents at least some evidence of a sound policy shift away from excessive reliance on costly institutional care.

The initial cost estimates assigned to the occupational therapy provision demonstrate a serious neglect of the actual numbers of personnel available to provide this service. They likewise indicate no awareness of the fact that occupational therapy is already a covered home health service now being provided under established criteria and patterns of practice. The occupational therapy provision is not a "new" home health service, coverage for which must be developed in embryo.

The Association has calculated a more reasonable, but by no means conservative, cost estimate. The Association's calculations assume that without implementation of the occupational therapy provision the Fiscal Year 1982 Medicare home health visit charges will be approximately $900 million. The Association further projects that occupational therapy visit charges will constitute approximately 2.2 percent or $19.8 million. The number of therapists required to provide this quantity of service will be approximately 1,200.

It should be noted that these figures are based on a straight line projection from 1976 data. They assume a continued growth of occupational therapist involvement in home health care, even without any change in the Medicare law. This assumption can be seriously questioned in light of the comprehensive occupational therapy personnel situation, as described below. If anything, therefore, these numbers might reflect a higher cost and degree of involvement than will actually occur.

Using these projections, the Association has calculated that, at most, the increased costs which could be attributed to the establishment of occupational therapy as a primary home health service is $9.9 million. This figure would represent a 50 percent increase in the use of home health occupational therapy. It would likewise involve the addition of approximately 600 new therapists into the home health area, an increase of from 6 percent to 9 percent of the total occupational therapy workforce involved in home health care.

Although the Association believes these estimates represent the outside limits of what the actual costs will be, they are certainly more realistic than other estimates assigned to the provision. These other estimates would show an increase of anywhere from 100 percent to 300 percent of the occupational therapy home health cost. They would likewise require the percentage of therapists working in home health to rise to anywhere from 12 percent to 24 percent of the total workforce. Without even addressing the question whether the beneficiary need for such increases can be documented, the Association contends that, even if the need exists, there are not sufficient numbers of therapists to provide such a substantial increase of service.

Review of the supply and demand status of occupational therapy personnel indicates that there will not be sufficient numbers of therapists available to provide the service required to meet these cost estimates. In brief, the current demand for occupational therapists substantially exceeds the supply. Moreover, there is no evidence to indicate that the growth rate of the profession will change sufficiently in the near future to remedy these shortages. Therefore, there is no reason to believe that establishing occupational therapy as a primary home health service will occasion a massive rush of therapists into home care delivery.

In recent years data collected from a variety of diverse sources clearly indicates that the supply of occupational therapists has failed to meet existing demand.

Critical shortages of occupational therapists exist in long-term care facilities. The 1975 "Long-Term Care Facility Improvement Study" of the Department of Health, Education and Welfare (DHEW) reported that 35 percent of the people in nursing homes need occupational therapy services and only 10 percent were receiving them. Moreover, a 1977 DHEW survey of nursing homes reported that 23 percent of the full-time occupational therapists positions were vacant.

The Bureau for the Education of the Handicapped (DHEW) reported that a 1978 survey of state school systems showed that 1,700 occupational therapists were employed during Fiscal Year 1978 and that 2,400 occupational therapists would be needed for Fiscal Year 1979. This represents an increase of approximately 40 percent.

Three of the nine state-operated MEDIHC (Military Experience Directed Into Health Careers) programs, which place "allied health" personnel in shortage areas and occupations, listed occupational therapy as a shortage occupation in their states in 1978.

In a 1979 survey of state occupational therapy associations conducted by The American Occupational Therapy Association, Inc., 58 percent of the state job placement services reported that there were more jobs than available personnel. A number of state-operated manpower programs have found the same situation. The State of Maryland, for example, reports that 35 out of 100 budgeted positions in the State Department of Health and Mental Hygiene are currently vacant.

As for the future, the Bureau of Labor Statistics (BLS) of the Department of Labor (DOL) in May, 1980 published projections of growth for different occupations in "Occupational Projections and Training Data" (Bulletin 2058). BLS projected that over the next ten years, there will be an average of 2,500 openings for occupational therapists each year, consisting of 1,300 new and 1,200 replacement openings. By 1990 this will represent a 100 percent increase in positions available for occupational therapists, a greater increase than for any other occupation or profession studied. As noted below, the capabilities of the present educational system fall far short of meeting this increased demand.

There is, moreover, no evidence to indicate that the demand for occupational therapists in other traditional settings, such as general and psychiatric hospitals, and rehabilitation facilities has declined or will do so in the immediate future.

In the context of these indicators of present and continuing demand for occupational therapists, consideration should also be given, on the supply side, to the capacity of the educational system.

The occupational therapy educational system adds approximately 1,700 new therapists to the workforce each year. This figure has remained constant for the last four years and falls approximately 800 therapists per year short of the 2,500 number needed to match the demand identified by BLS through 1990.

The occupational therapy educational system, moreover, shows no growth patterns which would immediately remedy this supply shortage. Over the past five years the numbers of faculty in the educational programs has remained constant. Over the last six years student enrollments have increased by only 4.2 percent. Since 1976, only six new educational programs have been opened. Existing occupational therapy educational programs have reached saturation, with the numbers of graduates leveling off at approximately 1,900 for each of the last several years, 1,700 of whom enter the workforce.

In this context, it should also be noted that, for 90 percent of the profession, close to five years of education and training is required before an individual can become an occupational therapist. For the other 10 percent, entry into the profession can be achieved within approximately three years, but only if a baccalaureate program has already been completed. Therefore, even if some unforeseen expansion of the educational system should occur immediately, the vast majority of the new therapists would not enter the workforce for another five years.

The Association believes, therefore, that an objective review of the occupational therapy personnel situation demonstrates the inaccuracy of the cost estimates attached to the home health provision. Even if the patient need for this degree of increase exists, there are not sufficient therapists available to meet it. We, therefore, believe the cost estimates cited above represent the outside limits of what this provision might actually cost. No estimate beyond these limits would accurately reflect a careful analysis of the occupational therapist workforce.

The Association further believes that in assessing the cost of the occupational therapy home health provision some consideration should be given to the cost reductions it will generate. It is not uncommon for an institutionalized patient to progress to a point where only the occupational therapy treatment is contributing to his or her continued rehabilitation. This person could be sent home provided he or she continues to receive occupational therapy, usually for some brief time. It is known, however, that the Medicare reimbursement restriction will ultimately mean that the needed treatment will not be continued. The person, then, is either discharged without the needed therapy, or, as frequently occurs, the costly institutional care is continued.

There are also instances when a person who resides at home and otherwise qualifies for home health care has a diagnosed condition which requires only occupational therapy. The Medicare restriction, however, precludes coverage for the service. The service is not given; the individual's condition deteriorates; and eventually institutional care is required.

Finally, an individual may be receiving home health occupational therapy on a covered basis together with other services. The need for the other services ends, but the occupational therapy treatment has not been completed. As a practical matter, the other services will be continued for the usually brief time required to complete the occupational therapy program.

In all of these instances the very unwise restriction which has been placed upon reimbursement for home health occupational therapy only adds to the total cost of the health care bill. Removal of the restriction, as Public Law 96-499 has effected, will eliminate these unnecessary costs, and therefore serve to offset somewhat the total cost of the provision.

Finally, the Association believes that retention of occupational therapy as a primary home health service provides at least one example of an appropriate and needed shift in the emphasis of health care policy. Individuals with first hand knowledge of health care practice frequently witness the pervasive reliance on institutional care which characterizes this policy. Although many factors contribute to the continuation of this reliance, none is more causative than the structure of the reimbursement system. The fact that at most only 2 percent of the total Medicare budget is spent on home care is certainly noteworthy in this regard. The removal of this and other barriers to the provision of home health care can only serve to encourage public and private reimbursers, practitioners, patients, and administrators to rely less on costly inpatient care as the dominant mode of service delivery.

In summary, then, the Association urges the Committee to retain occupational therapy as a primary Medicare home health service and comprehensive outpatient rehabilitation facilities as Medicare providers. The Association believes these provisions respond appropriately to the serious need to improve access to outpatient care. The Association urges reassessment of the initial and unreasonable cost assigned to the occupational therapy provision. Finally, the Association suggests that increased utilization of outpatient and home health care will ultimately reduce the size of the health care budget.

Children's Hospital and Health Center, San Diego, Submitted by Blair Sadler, President, Children's Hospital and Health Center

I am Blair Sadler, President, Children's Hospital and Health Center, San Diego. It is in this capacity that I submit for the hearing record this testimony regarding the Administration's proposal to repeal Title V of the Social Security Act dealing with child health programs.

Children's Hospital and Health Center, San Diego (CHHC) is a 158-bed tertiary care regional pediatric center serving two million people in San Diego and Imperial

Counties. The Institution has many special programs, including a hospital based child protection program and one of the largest speech, hearing, and neurosensory centers on the West Coast. CHHC also conducts a substantial amount of research in many aspects of children's health.

From the outset, may I emphasize that CHHC opposes the Administration's proposal to repeal Title V of the Social Security Act dealing with child health programs and to create an unrestricted block-grant to the states for health services. While it has been said by some in the Administration that no one has a right to particular services, we believe that the adult population does have the obligation to provide the basic fundamentals of nourishment, education, guidance—and good health care—to enable each child to have the potential to emerge as a productive and responsible member of society. The Federal government can and does play a role in this process. Unfortunately, in the competition among interest groups for those resources which Congress allocates for health services, the voices of children may be crowded out. For that reason we believe that those with the special responsibility to children, such as children's hospital, must take an active role. In this case, the role is one of urging that Federal dollars that are currently being appropriately and effectively spent for the health of our children not be dissipated without regard to the merits of the individual programs affected.

Since 1935, the maternal and child health programs authorized by Title V of the Social Security Act have been the major Federal health endeavor aimed specifically at reducing infant mortality, promoting the health of mothers and children, and locating and treating crippled children or children who suffer from conditions leading to crippling. These provisions were contained in the original Social Security Act because Congress recognized the special vulnerability of children and their need for special consideration in matters of health services.

It is no mere act of oversight that has led Congress to reaffirm its commitment to this program repeatedly since 1935. Rather, the Title V program has been highly successful in reducing infant mortality, decreasing the incidence of mental retardation, and improving the overall health of children. These services place a heavy emphasis on prevention, and hundreds of thousands of infants and children have, because of these services, become productive adults rather than dependent charges upon society. This national commitment to improve child health has been achieved through a partnership between the Federal and state governments, a partnership that recognizes the states own particular needs while coordinating immunization, cardiac, perinatal, and genetic health programs, to name a few, on a regionalized basis. As the Select Panel for the Promotion of Child Health recently concluded in its report entitled Better Health for our Children: A National Strategy, the Federal government has, in fact, exercised a beneficial and irreplaceable leadership role vis-a-vis the states in improving the delivery of maternal, child health, and crippled children's services.

The proposed repeal of Title V and the substitution of an unrestricted health services block-grant to the states would have a devastating effect on the longstanding maternal and child health services and crippled children's programs. Some illustations of this negative impact are as follows:

1. LOSS OF FISCAL COMMITMENT BY STATES

Under the current legislation, states are required to match a portion of the Federal funds and to identify a distinct administrative unit to develop a state plan to implement maternal and child health and crippled children's services. Under the Administration's proposal, however, it appears that states would no longer be required to continue to match the child health funds or to develop and implement a state child health plan. This potential loss of financial and administrative support will severely impact on the scope and breadth of services that will be available in the future for child health.

2. IMPAIRMENT OF PROGRESS IN CLINICAL RESEARCH AND TRAINING

Under the Administration's proposal, the Office of Maternal and Child Health in the Department of Health and Human Services would be eliminated. This would mean that the valuable Federal role in providing technical assistance to states regarding the health needs of children, in training health care professionals crucial to services for impaired children, and in supporting applied and clinical research of regional and national significance important to improving health services to children would be abolished. Although the Administration has suggested that child health researchers could compete for funding through NIH, this is not a viable alternative since NIH itself is undergoing cutbacks, and since nonbasic science research is not a high funding priority within NIH.

3. ELIMINATION OF QUALITY CONTROL MECHANISMS

The consolidation of child health services into a block-grant would eliminate those quality control mechanisms which have been developed for categorical programs based upon national standards formulated by the medical profession as a whole. It would be difficult to establish national data on children's health needs, on the services provided, or on their effectiveness in meeting national goals. The loss of the Federal role as a model, a resource, and a guide in the development of standards for child health services could not be compensated for by the individual states or by the private sector.

In order to avoid the likelihood of these harms, the Children's Hospital and Health Center urges this Committee to support the retention of Title V child health programs which have a proven record of providing the resources necessary to improve the health of children in a cost-effective manner. We cannot afford to lose the benefits of these programs by abolishing the Federal role at a time when budgetary constraints foreshadow a loss of funding for Federal programs based not simply on their benefits to society but on the ability of their beneficiaries to organize effective lobbying campaigns for their retention. To take the risk is to jeopardize the health of our country's most valuable resource—our children.

Although CHHC recognizes and supports the Administration's mandate to reduce Federal outlays, it believes that assistance for the health of our children should not be sacrificed. Thus, we support the continued retention of the Title V child health programs at their current funding levels of $411 million. We also recognize that although Title V programs are successful and necessary, they can and should be modified and improved in ways which will increase the overall effectiveness and efficiency of federally subsidized child health services. For example, Title V offers an appropriate vehicle for the consolidation of various small categorical child health programs to meet the problems of fragmentation and duplication of services. Accordingly, we look forward to reviewing and commenting on the legislation to be proposed by this Committee.

It is our hope that this Committee will favorably consider these recommendations.

TESTIMONY OF THE COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING

The Council of Home Health Agencies and Community Health Service (CHHA/CHS), one of five membership councils of the National League for Nursing, is a coalition of 450 providers participating in the Medicare and Medicaid programs. These home health agencies offer preventive, supportive and health education programs along with the basic home health services. We are pleased to have the opportunity to present our views on the President's budget and its effect on home health services and financing.

CHHA/CHS believes that home health services must be further expanded to assume their rightful place as an integral part of the health care system and to assure access to such care for those who need it. We supported passage of those provisions in the Omnibus Reconciliation Act of 1980, now Public Law 96-499, which made significant and needed changes to the home health benefits covered under Medicare. We are here today to urge that this Committee and the Congress not support the Administration's proposal to repeal those provisions.

The Administration's proposed budget for fiscal year 1982 recommends repeal of the provisions of P.L. 96-499 which would remove the 100-visit limit on home health services and add occupational therapy as a qualifying home health benefit. We are here today to speak against repeal of these provisions and to suggest that repeal in the long run would be counterproductive of the Administration's goal of making Medicare and Medicaid more cost effective programs. Further, we also want to comment on the staff proposal to impose coinsurance on Medicare home health visits which is included among a list of additional savings options presented to the committee last month.

ELIMINATION OF 100-VISIT LIMITATION UNDER PARTS A AND B

According to the latest data available from the Health Care Financing Administration, fewer than one percent of the beneficiaries using Part B home health services exhausted the 100 visits and less than two percent of those using Part A services received more than 100 visits. The average number of annual visits per person served was about 23.

These data indicate that eliminating the 100 visits limitation will increase Medicare cost by only $6.9 million in fiscal year 1982. On the other hand, retaining this amendment will provide needed service to the small percentage of individuals who

do need them—visits that may prevent or delay need for more costly institutionalization.

COINSURANCE FOR HOME HEALTH VISITS

We note that the Finance Committee staff has identified alternative savings options in a report to the Senate Budget Committee. Among the alternatives are two proposals for coinsurance on home health visits under Medicare which we oppose. As you know, in 1972 Congress repealed the 20 percent coinsurance provision applicable to home health visits covered under Part B. To reinstate a coinsurance requirement for home care services under Part A or Part B or both would be counterproductive—cost-inducing rather than cost-reducing.

We recognize that the imposition of coinsurance on health services can reduce utilization—both inappropriate and needed utilization. While we understand that this device can be a deterrant to excessive utilization, we do not believe that its application to home health services is appropriate. As the statistics cited earlier reveal, home health services constitute a relatively small portion of Medicare covered services and expenditures. In fact, a strong case can be made that such services are underutilized. In significant part, the underuse denies the program economies that result from postponement of or reduction in the need for more costly forms of care, post-hospital nursing facility care, for example.

The costs of administering a coinsurance requirement could signficantly reduce or eliminate any projected program savings. Specifically, the agencies would incur additional costs associated with necessary modifications in their billing systems and submitting a statement to the carrier or intermediary and the beneficiary. In addition, expenses associated with collection activities and with an increase in bad debts would be borne in whole or in part by the Medicare program. A substantial portion of the users of home health services cannot afford to pay the coinsurance and the coinsurance would become a bad debt covered by Medicare or would be paid by Medicaid, which is, of course, financed in part from Federal funds.

For these reasons we urge the Committee not to adopt this alternative as a cost-saving measure.

OCCUPATIONAL THERAPY AS A QUALIFYING HOME HEALTH SERVICE

The addition of occupational therapy as a qualifying home health service removes another arbitrary barrier to access to home health services. There are situations when occupational therapy is the only service needed. Indeed, we know of cases where patients are kept in hospitals for the sole purpose of obtaining occupational therapy services. while in some home health agencies it may create an incentive to continue qualifying services beyond the point they are required so as to assure coverage for occupational therapy. Addition of occupational therapy as a primary home health service would allow transfer of those patients to the home when it is a less costly service setting and would remove any incentive for the provision of unneeded qualifying services. Moreover to the extent that patients forego occupational therapy because it is not covered at home, they are likely diminishing the opportunity to be self-sufficient.

According to information from our members, the numbers of patients who would benefit from this provision is modest. While the CBO has estimated that this provision would cost $35 million in fiscal year 1982, more difficult to quantify, but nonetheless real, is the potential savings in hospital days and other forms of institutional care. We believe over the longer term that this provision could save scarce program dollars. The costs could be more than offset and thus the net effect could be a substantial cost savings.

The enactment of P.L. 96-499 recognized the cost effectiveness of adding OT services to the other qualifying or primary home health services. We hope this Committee will not support efforts to repeal the provision.

PROPOSALS FOR REDUCING MEDICARE PROGRAM COSTS

In addition to the proposals included in the Administration's proposed budget, there were some provisions approved by this Committee during the 96th Congress some of which have recently been recommended by the Senate Budget Committee. One which causes us particular concern is the limitation on home health agency per visit reimbursement.

Under current regulations, home health agency cost limits are based on the 80th percentile of average agency costs with separate schedules for facility based (i.e., hospital-, SNF-, or rehab-based) agencies and for free-standing agencies.

The Budget Committee recommendation would revise the cost limits on home health agencies by lowering the percentile and by further limiting reimbursement

to the maximum of the per diem Medicaid rate paid to a skilled nursing facility for each covered visit.

We support use of weighted (by number of visits) average costs rather than unweighted costs in computing limits so that the lower costs of more efficient large agencies would have greater weight and thereby constrain or reduce the increase in cost limits. Also, we encourage the use of a single schedule for all agencies rather than separating facility-based and free-standing agencies. An effect of the dual set of cost limits has been an increase in the numbers of hospital- and other institutional-based agencies that have become Medicare-certified in the past year. Since these types of agencies tend to have higher costs than the free-standing agencies, the use of dual limits increases the total cost to the Medicare program.

We do not support, however, changing the percentile from the 80th to the 75th. Lowering the cost limit from a base of the 80th percentile of average agency costs (as in current HCFA regulation) to the 75th percentile of average visit costs (as recommended in the 96th Congress by the Finance Committee and now by the Budget Committee) will have a serious effect on between 30 and 50 percent of agencies. According to HCFA data an estimated 50 percent of agencies will be reimbursed at less than actual costs if the limits are figured at the 75th percentile and are applied on a discipline by discipline basis. Fewer agencies (30 percent) will be negatively affected if the limits are applied on an aggregate (average visit cost), rather than individual discipline, basis.

The imposition of limits at the 75th percentile will reduce the number of financially viable agencies which in turn will mean diminished access to home health services by program beneficiaries. Lowering the percentile will result in an initial loss of reimbursement to those agencies falling between the 75th and 80th percentile, but the shortfall in payments to agencies above the 80th percentile will be substantial, likely forcing some to close. No real savings will accrue if scores of agencies are forced out of business and Medicare beneficiaries have to forego needed services which can lead to more costly alternatives to home health services.

Perhaps the most devastating portion of this proposal is the link between home health agency costs and Medicaid per diem payments to skilled nursing facilities. The arguments against this proposal set forth last year when the matter was before the budget reconciliation conference committee were apparently convincing inasmuch as the final bill did not include the provision. The following is excerpted from a telegram sent to all members of the Finance Committee last June from several state and national home care organizations outlining the concerns regarding the SNF linking:

"The coupling of home health reimbursement to that of SNF's does not take into consideration the frequent significant differences in the level of care required by home care patients and by those patients occupying Medicaid SNF beds. The two should not be compared because of key differences in both the types of patients and the preparation of staff involved. Home health agency patients typically require a higher level of care and more complex services than those in Medicaid SNF beds. The home health agency care givers, in turn, must employ a broad array of professional skills to meet the plethora of health and related needs of patients in an isolated health care environment. Indeed, on an hourly or per diem basis, the professional services rendered by HHSs combined with travel and other related expenses may appropriately cost more than 24 hours in a SNF.

"On the surface, coupling the two would suggest that home health services are more costly to the taxpayer. In most instances this is not the case because Medicare home health services are, by definition, intermittent. The only proper way to measure comparative costs is by looking at a time interval greater than one day. On average, a month of SNF care costs the taxpayers 300 percent more than a month of home health care."

We hope this Committee will support our contention that linking the cost of home health visit with Medicaid per diem SNF payments is inappropriate and that this position will be brought to the attention of HCFA.

SUMMARY

CHHA/CHS appreciates the Administration's attempt to control the spiraling inflation and unconstrained growth in federal expenditures. And we recognize that limits on health and social programs are necessary to accomplish these goals. It is our hope that the Congress will achieve appropriate savings in a reasonable and equitable manner.

We believe that appropriately utilized home health services can help in the long run to make federal health spending more cost effective. We urge this Committee to reaffirm its position of last year and reject the proposals to repeal the elimination of the 100 visits limitation and the addition of occupational therapy as a qualifying

home health service. Further, we urge you to oppose reimbursement proposals that would link home health services to SNF payments or lower the percentile limit at which home health costs are computed.

We appreciate the opportunity to present our views and we welcome any comments or questions. Thank you.

STATEMENT OF NATIONAL ASSOCIATED BUSINESSMEN, INC.

National Associated Businessmen, Inc. (NAB) appreciates this opportunity to express our support for the President's proposed spending reductions. NAB is a nonpartisan business league organized in 1946 to promote sound fiscal and economic policies.

BIG GOVERNMENT IS WRECKING OUR ECONOMY

Today nobody would deny we face a deteriorating economic situation characterized by galloping inflation, high interest rates, stagnating productivity growth, increased unemployment, and grossly inadequate capital formation. The underlying forces causing these problems have been building up for many years and unfortunately cannot be dissipated instantly or painlessly.

Nonetheless, although our economic problems are serious as well as complicated, we are confident that reformed government policies can eventually solve them. The President's proposed spending reductions certainly move in the right direction and mark a decisive break with the past.

NAB does not subscribe to the view that these ills are unrelated products of mysterious or obscure origin. To the contrary, as the President has pointed out, government is the source of most of our economic maladies. The economic policies of interventionism and inflationism initiated at the federal level have resulted in just that state of affairs conservative economists predicted long ago: planned chaos.

The liberal program of big government, confiscatory taxation, deficit spending, and easy money have been fully implemented with a vengeance over the last 15 years, at least. From 1965 to 1980 federal transfer payments jumped from $32.5 billion to $271.2 billion, an increase of 739 percent. The federal budget leapt from $118.4 billion to over $579 billion. In the same period federal spending as a percentage of GNP increased from 18 percent to over 22.5 percent.

Meanwhile we were assured that the bureaucrats could "fine-tune" the economy, and that the skyrocketing federal debt was of no concern since "we owe it to ourselves." If economic activity slowed, all we had to do was print money to perk things up a bit and ensure full employment. If monetary growth caused rising prices the solution was clear—increase government power further with higher taxes and wage and price controls. In retrospect it seems evident that these doctrines have failed miserably, and served only as a rationale to justify more encroachments on the private sector.

For a long time the conservative view has emphasized the self-aggrandizing nature of the welfare state, demonstrating its tendency to corrupt representative government and undermine the private sector. According to this interpretation, the expanding welfare state would sap the productive vitality of society with confiscatory taxation, and in all probability eventually resort to monetary expansion to finance its ever-extending program.

The central issue is that the unrestricted welfare state generates strong political and economic forces for more government—and that these forces are capable of destroying the market economy. Government promotion of subsidized consumption at the expense of investment has now reached critical proportions.

THE PRESIDENT'S SPENDING REDUCTION PROPOSAL

It is clear that the President is determined to turn the tide in this process. The Administration calls for slashing projected spending increases by about $51 billion, resulting in a fiscal year 1982 budget of $695.5 billion. Unfortunately, even after this action federal spending would still rise about 6 percent over fiscal year 1981, producing a deficit estimated at $45 billion. NAB fully supports all of the proposed reductions and urges that deeper cuts be made. We favor acceleration of the effort to abolish the Cabinet-level Departments of Energy and Education.

In an ideal political environment all kinds of subsidies and income redistribution programs (and the bureaucracies that administer them) could be sharply slashed. These federal activities not only increase spending but also distort efficient resource allocation and eonomic incentives. Federally-owned businesses should be sold to private enterprises and thereby become taxpayers instead of tax consumers. The federal postal monopoly should be eliminated and its facilities sold to private

companies. The pay scales and retirement benefits of federal employees could be adjusted downward to achieve parity with the private sector. Double indexing of federal pension payments should be ended. Other government related cost of living adjustments are also obviously very expensive and deserve close scrutiny. An overhaul of sacred cows such as Social Security ($140 billion) and Medicare ($45 billion) will likely become necessary.

Deeper cuts in multilateral development assistance might serve to highlight the important connection between development and capitalism. Until Third World nations give up socialism for capitalism there is little the United States or anyone else can do to help them achieve industrial and economic progress. Funds provided by the United States will be wasted and probably strengthen the position of bureaucratic forces with a vested interest in the bankrupt ideology of socialism.

EXCESSIVE SPENDING GROWTH INDUCES DEFICIT FINANCING AND CREDIT EXPANSION

NAB does not accept the notion that a direct mechanical link between deficit spending in a given fiscal year and monetary expansion exists. However, recurring deficits boost the federal debt and the amount of government securities offered on financial markets. Rapid growth of government debt without commensurate increases in the amount of savings will crowd-out private investment, exert upward pressure on interest rates, and undermine capital formation, with particularly disruptive effects in capital intensive industries or other interest rate sectors such as small business and housing.

To accommodate this pressure and prevent a credit crunch the Federal Reserve often feels obliged to monetize federal debt by open market operations. This procedure normally augments the reserve accounts of member banks, fueling a substantial expansion in the quantity of money and credit. Repeated injections of this high-powered money is the primary cause of the enormous credit expansion and inflation of the last ten years.

Between 1970 and 1980 the federal debt rose 138 percent, from $382.6 billion to $914.3 billion. In this same period Federal Reserve credit jumped 94 percent, from about $67 billion to almost $130 billion. Meanwhile M_2 more than doubled, from a little over $400 billion to $950 billion, reflecting a startling expansion in the quantity of money and credit. The resultant calculation of an inflation premium by lenders has forced nominal interest rates soaring to record highs, choking off economic recovery and strangling entire industries. Furthermore, indices of banking and corporate liquidity have plummeted to potentially dangerous levels.

Accelerating inflationary expectations have deprived monetary expansion of any stimulative impact that may have existed and also destabilize financial markets and investor confidence. It is unnecessary to discuss in detail the other profoundly destructive effects of inflation with respect to economic calculation, efficiency, savings, and investment. Suffice it to say that economic conditions are sufficiently unsettled to warrant deep concern about the future.

Consequently, we fully concur with the President's appraisal that the only alternative to deep budget cuts is economic calamity. The President's program will ultimately increase incentives for savings, capital formation, and productivity growth by trimming government and facilitating tax relief. Inflationary forces and the encroachment of government on the private sector must be halted swiftly to preserve our way of life.

Thank you.

MARCH OF DIMES,
Washington, D.C., April 21, 1981.

Hon. ROBERT DOLE,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR DOLE: It is my present understanding that the block grant relating to health matters is now going to be considered in the Senate Finance Committee. For this reason and because the development of genetic services is a major concern of the March of Dimes, I am enclosing a statement on behalf of our Foundation concerning the continuation of the National Genetic Diseases Act.

We would greatly appreciate the inclusion of this statement in the record relating to the preventive health block grant.

Thank you very much for your consideration.

Sincerely,

CLYDE E. SHOREY, Jr.,
Vice President for Public Affairs.

STATEMENT OF CLYDE E. SHOREY, JR., VICE PRESIDENT FOR PUBLIC AFFAIRS, MARCH OF DIMES BIRTH DEFECTS FOUNDATION

Mr. Chairman and members of the committee, my name is Clyde E. Shorey, Jr. and I am Vice President for Public Affairs of the March of Dimes Birth Defects Foundation. I am pleased to present this statement concerning the reauthorization of the National Genetic Diseases Act.

The March of Dimes opposes the inclusion of genetic services in a block grant as proposed by the Administration. Only 34 states have been able to start genetics programs with Federal funding. In many of these states this new program, which has become tremendously cost effective, has not had time to become an established part of the health system. In these States and in those without a federally funded genetics program the future of genetic services would be jeopardized if this program were included in the proposed block grant.

The National Genetic Diseases Act was first passed in 1976 and reauthorized in 1978 as Part A, Title XI of the Public Health Services Act. Funds were first appropriated for fiscal year 1978 so there have been just over two years of experience in the operation of the program. The primary objective of the program is to deliver genetic disease information and to provide education, testing and counseling services and medical referral for all persons seeking information who are suspected of having or transmitting a genetic disorder.

During the first two years the funding for this program was limited to $7.567 million which covered both grants for genetic services at $4 million and $3.567 million for sickle cell screening and education clinics. With this level of funding grants were made to 21 states for genetic services and to 18 sickle cell clinics. In fiscal year 1980 the level of funding was increased to $11.567 million resulting in grants to 34 states for genetic services and to eleven sickle cell clinics. Seven sickle cell clinics were consolidated into full genetic service clinics. For fiscal year 1981 the level of funding has been increased to $13.145 million and it is estimated that the number of grants to states can be increased to approximately thirty-eight.

In the United States, one child in every 150 to 200 live births—or 15,000-20,000 infants per year—have a major genetic anomaly. It has been estimated that 12 million Americans carry true genetic diseases; 36 percent of all spontaneous abortions are caused by chromosomal defects; 80 percent of the incidence of mental retardation in this country is genetically related. Estimates have been made that at least one-quarter of all hospital beds and places in institutions for the handicapped are occupied by persons suffering from conditions that are wholly or partly genetic in nature.

Reduction of damage from genetic disease in most cases is dependent on identifying carriers of genetic disease traits through evaluation of family history and screening and diagnostic procedures. Carrier detection of such genetic disorders as thallasemia, sickle cell anemia and Tay-Sachs disease is possible.

Newborn screening of all live births can detect at least six different conditions causing mental retardation including PKU, hypothyroidism and galactosemia. If promptly detected at birth, severe mental retardation can be avoided and the baby will be able to lead a substantially normal life. All states are currently testing for PKU but substantially fewer are testing for the other conditions. The same blood sample can be used to detect all these conditions and in addition now can be used to detect sickle cell disease.

The Center for Disease Control has estimated that a nationwide hypothyroidism control program added to PKU screening should cost less than $5,900,000 and should produce a savings to society of $52 million a year. The State of California has estimated that adding hypothyroid and galactosemia screening of newborns to its present PKU screening program would increase its total costs of screening and treatment for victims of the three diseases from its present cost of $3.8 million to about $4.7 million. At the same time the long term costs averted by such a program for all three diseases would total an estimated $169 million—producing a cost benefit ratio of 36 to one. But the cost benefit ratios are not as important as the 35 treated PKU, galactosemia and hypothyroid cases in California each year that would lead healthy normal lives instead of being mentally retarded.

In addition to the identification of carriers of genetic disease traits and the testing of newborns so that those with a genetic disease may be identified for prompt treatment, genetic service centers also provide prenatal diagnosis to determine whether a fetus believed to be at-risk for a particular birth defect is or is not actually affected. Prenatal diagnosis is performed through the use of sonography, fetoscopy or amniocentesis. Through sonography high frequency sound waves produce a picture of an in utero fetus. By means of fetoscopy it is possible to obtain a direct view of the fetus and obtain fetal blood and skin cells. Amniocentesis is the process of withdrawing amniotic fluid for study of fetal cells. Through these tech-

niques it is possible to determine the presence or absence of all chromosome disorders, some malformations and approximately 90 biochemical disorders in utero.

There are many benefits to be realized from prenatal diagnosis, some of which are now existent and some of which are soon to be realized through rapidly developing progress in research. With the assistance of prenatal diagnosis deliveries can be planned to occur in hospitals staffed and equipped to begin immediate treatment of the defect. Some birth defects are best managed by inducing early labor and beginning treatment to limit the extent of damage. Infants with some birth defects should be delivered by Caesarean Section to prevent increased damage to fetal organs during the birth process.

Prenatal diagnosis permits treatment in utero of some conditions characterized by destruction of fetal red blood cells and of a growing number of disorders which can be treated by administering massive doses of specific vitamins to the mother during pregnancy.

The provision of genetic services information, education, testing and counseling therefore produces the following benefits: a reduction in the number of severely handicapped and dependent individuals and of the tremendous costs to society; relieving the anxiety of parents during pregnancy who are bearing normal children, or giving them the opportunity to prepare for the arrival of a child with defects; identification of treatable disorders so early intervention can be initiated; counseling prior to pregnancy so that informed decisions on pregnancy can be made; and early identification of major defects that result in a fatal outcome, severe mental retardation or crippling conditions so that parents may make informed decisions.

The funds made available under the National Genetic Diseases Act are used to support and expand statewide and regional genetic services delivery systems by building on state health departments, specialized service centers in universities and hospitals, together with voluntary and community service organizations and private physicians. Grants are made to state health departments and university or community centers in accordance with a state plan. The grants are coordinated and linked to other federal health care programs including Maternal and Child Health Programs, Crippled Children's Services Programs, Hemophilia Treatment Centers and Medicaid.

Few states have laws mandating genetic service programs other than requirements for newborn screening for PKU and, in a smaller number of states, newborn screening for hypothyroidism, galactosemia and several other similar genetic conditions. Funding for genetic services is extremely limited since only a fraction of the costs are covered by third party payments, including Medicaid. Except for the addition of federal funding under the National Genetic Diseases Act, most of the delivery of genetic services is limited to approximately 100 major medical centers in which genetic service clinics were established with the individual institutions' own source of funding and often with the assistance of the March of Dimes.

Program service grants under the federal program are used to supplement existing genetic service centers and to initiate satellite clinics in an effort to expand the services to all the people in each state. With the limited amount of funding available in fiscal year 1980 for this program ($11,567,000), grants could be made to only 34 states for areawide genetic services and to 11 sickle cell screening and education clinics. Seven sickle cell clinics, previously funded independently, are now merged with and funded through genetic service grants. These 45 projects are located in 37 states and their funding totals $10,800,573.

The balance of the appropriation is used to fund various support services. A nationwide education information program includes the National Clearinghouse for Human Genetic Diseases, the development of educational curricula for junior high schools and the initiation of training programs for health professionals. The federal program provides laboratory support to the states in the areas of hemotology, cytogenetics and biochemistry for genetic services through an interagency agreement with the Center for Disease Control. These are highly technical areas requiring the most advanced procedures. CDC services to the states include development of laboratory standards, training manuals and laboratory courses, bench training, proficiency testing and evaluation of state laboratory operations. Technical assistance is also provided for the development and operation of the statewide genetics projects.

The Administration has proposed inclusion of funds for genetic services in a block grant to the states. One of the major reasons, besides a cut in funding, for the block grant proposal is to allow the states to plan their own health service programs. This objective already exists under the National Genetic Disease Act as all grants are required to be made in accordance with a state genetics plan.

The 25 percent reduction in funding would result in only $9.75 million being allocated to the block grant based on current genetic services funding. This is more

than $1 million less than the current level of the 34 grants to genetics clinics and in addition does not provide for administrative costs at the federal and state level or the current cost of support services provided by the federal government.

Because of the newness of these health services and the consequent delay in establishing the structure for administering them, most states are not ready to provide and administer genetic services without the supporting services from the federal level. The services would suffer severely if the laboratory services, the education program and the technical assistance were lost. Furthermore, in the competition for funds at the state level, genetic services would get lost since it is generally not an established part of the health system.

In addition, the existing proposal for block grants would separate genetic services from Maternal and Child Health and Crippled Children's funds, an error which would fragment services and result in increased administrative costs.

We believe that it is important to advise this Committee of the strong support for this program by Secretary Richard S. Schweiker during his years as Senator. Attached to this statement is a letter from then Senator Schweiker dated August 13, 1979, after the Senate Appropriations Committee, in which he played an active role, had doubled the appropriation for genetic services for fiscal year 1980.

The March of Dimes opposes the inclusion of genetic services in a block grant as proposed by the Administration. We urge this Committee to maintain the National Genetic Diseases Act as part of a separate legislative authority which assigns responsibility at both federal and state levels for services for mothers and children. We believe it is essential to maintain a federal role which includes program development and standard setting, research and training, technical assistance and laboratory services.

We appreciate your consideration of our views.

Enclosure.

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C., August 13, 1979.

MR. CLYDE E. SHOREY, Jr.,
Vice President for Public Affairs,
The National Foundation March of Dimes, Washington, D.C.

DEAR MR. SHOREY: I appreciate your letter and kind remarks regarding our recent action in the Appropriations Committee on behalf of Genetic Information and Counseling. As you know this has been an activity for which I have long been in support. The sizeable increase which the Appropriations Committee approved reflects the Congressional concern and priority which has been placed on these activities. From my own perspective I strongly believe that these types of screening and counseling programs will play an important role in not only preventing serious birth defects but also averting a greater number of abortions.

Your foundation should be commended for the marvelous work it has done informing the Congress of the importance of these activities.

Thank you for contacting me and I appreciate your continued support.

Sincerely,

RICHARD S. SCHWEIKER.

NATIONAL CATTLEMEN'S ASSOCIATION STATEMENT FOR SENATE FINANCE COMMITTEE HEARINGS ON ADMINISTRATION'S SPENDING REDUCTION PROPOSALS

The National Cattlemen's Association—some 300,000 strong—are in agreement with the Administration's economic goals. They support the Administration's efforts to return our economy to a non-inflationary growth path. Cattlemen have not asked for and, in fact, have discouraged increased government intervention in the cattle industry. Cattlemen have, moreover, worked for a lower level of government spending and reduced and more cost effective regulation because we believe this would lead to a strong economy and provide the setting for a profitable cattle industry.

In general there are five areas we believe will be beneficial to the economy and to the cattle industry:

1. Taxes.—Current tax laws are biased toward consumption at the expense of investment and savings. The high rate of inflation has compounded this problem. If agriculture is to meet future demands, a reduction in income taxes is essential. Efforts are also needed to simplify the tax law and to increase certainty as to tax consequences.

Tax laws should encourage capital formation and NCA supports laws providing for speedier depreciation and a broadening and liberalization of the investment tax credit.

Estate taxes must also be modified to allow for orderly transfers of family operated farms and ranches. This would reduce disruptions and loss of output typically associated with death and breakup of efficient operations.

2. Regulations.—Both producers and processors in our industry are suffering under excessive regulations in terms of coverage, cost and effectiveness. Because many cattle operations are relatively small, administrative costs of regulations frequently exceeding any potential benefits results only in losses or discontinuation of cattle operations. On top of this governmental personnel too frequently ended up interpreting and evolving regulatory goals not envisioned by Congress.

3. Agricultural research.—Support for research has declined in real terms over the last decade. Research expenditures are investments which flow to the public. Cattlemen need the benefits of accelerated research efforts to fully utilize the abundant available supply of renewable resources (forage) in its conversion to high quality protein beef.

4. Foreign markets.—While we know there is a great and growing demand for quality beef in Europe and Japan, our product continues to be severely restricted by their laws and regulations. By tariff and non-tariff means, foreign countries have kept our beef from their shores while the U.S. market remains open.

5. Government policies.—Government statements and guidelines not supported by scientific data on the health and nutritional value of meat and meat products have raised unnecessary concerns in the minds of consumers. Reckless statements about products used in producing beef have similarly caused concerns for consumers and producers.

The National Cattlemen's Association will cooperate with government in modernizing beef grading standards in response to consumers desires and needs. At the same time, it should increase efficiency of production which should keep beef prices more competitive with other high protein foods. Similarly, the industry is working toward a more wide spread use of the most efficient technology in producing and processing beef.

Finally, last month, NCA's 142 member Board of Directors met in Washington and spent two days visiting members of Congress and the Administration. The major focus of these visits was to encourage support for the Administration's proposals. Attached appendixes 1. Dealing with Inflation, 2. Dealing with Taxes and Capital Formation, and 3. Dealing with Spending Cuts, were given to Board members prior to their visits and stress the need to support the Administration.

APPENDIX 1

Inflation backgrounder

Few people have anything nice to say publicly about inflation. If it possessed physical attributes, inflation would be public enemy No. 1 and no effort would be spared to put it away. But, inflation can't be seen, held, smelled, or even described to everyone's satisfaction. Yet, we appear to measure it and even forecast it.

Inflation doesn't mean all prices rise at the same rate. This variation in relative price movements has caused an industry to grow up on how to beat inflation. From gold sellers to realtors, and from participation in the underground economy to pet government programs, the battle cry is heard on how to prosper with inflation. Social security recipients, government pensioners, those covered by cost of living adjustments, introduction of escalating mortgages, etc., are tied to inflation and provided protection, in part, from inflation.

On the other hand, economic growth is reduced and distorted by these efforts as well as non-productive programs to protect assets from inflation. Everyone and no one is held responsible for inflation and so attempts to rein it and meet criticisms about who will pay and who will reap the benefits. While the causes and cures of inflation remain elusive, the number of people who think they can or will benefit from inflationary programs is large and possibly growing.

What then, is inflation's ontology—the nature of its existence? Why is it inflation persists whether viewed temporally, over time, or spatially, around the world? How does the fact of inflation fit with our feelings about inflation's consequences? A review of employee compensation for seven countries during the last 12 years shows:

HOURLY COMPENSATION GROWTH

[In percent]

	Nominal	Real
United States	61.7	15.0
Canada	100.6	32.5

HOURLY COMPENSATION GROWTH—Continued

[In percent]

	Nominal	Real
Japan	818.2	251.0
France	424.5	102.0
West Germany	636.0	342.0
Italy	482.0	80.0
United Kingdom	316.0	15.9

The United States has the lowest rate of increase in nominal or dollar wages (61.7 percent) as well as the lowest rate of inflation except for West Germany. However, the United States also has the lowest wage increase in real terms (15.0 percent)—adjusted for inflation—and had, and has, the highest unemployment rate except for Canada. Further, the United States has the poorest rate of economic growth except for the United Kingdom. In short, the United States with a relatively good performance with regard to inflation, has failed in terms of income, employment, and economic growth.

Over the last ten years, the United States manufacturers' share of World Market has declined by 23 percent while imports of autos have grown from 8 percent to 30 percent, steel from 9 percent to 15 percent, and consumer electronics from 10 percent to 50 percent. Today, the United States has the highest percent of obsolete plants and lowest percent of capital investment. Since 1970, Japan's relative per capita income has risen from 40 percent to 60 percent of the United States while West Germany's has grown from 68 percent to 105 percent and Sweden's from 90 percent to 112 percent. The lower U.S. inflation rate has not prevented a relative decline in United States efficiency.

Other factors affecting United States inflation and growth were: Defense expenditures two to seven times that of other countries; days lost due to strikes at least six times other countries; failure to promote and foster industries with competitive advantage as do other countries; less dependence on oil imports and thus less prepared for oil shocks of 1973 and 1979; a relatively high level of regulation impacting environment, production, and marketing; labor force that includes 70 engineers and scientists per 10,000 versus 400 for Japan, while employing 20 lawyers and 40 accountants versus Japan's one and three, respectively; service employment growing three and one-half times faster than manufacturing; speculation (measured by futures contracts) up 458 percent over 1970; and white collar crime costing business $44 billion annually.

Clearly, inflation is more complex and more individualized than most believed. The economic structure, the social/political relationships, use and acceptance of technology, labor/management relationships, position in the World among others are important factors affecting inflation and in shaping policies to deal with it. Thus, simple and one time solutions to reduce inflation such as balance the budget or reduce monetary growth or end regulation or stimulate investment or lower taxes, etc., isn't enough.

President Reagan's program, if nothing else, recognizes inflation's complexity and necessity of dealing with the entire spectrum of probable causes. Inflation must be attacked at its many sources while real economic growth is stimulated.

The President's program calling for a broad and balanced attack on the causes of inflation and slow economic growth needs our stong support because it is right on target. Failure to enact those measures because of special or provincial interests could mean years of slow growth and continued inflation.

Cattlemen and inflation

Cattlemen are ill-equipped and ill-situated to deal with inflation. They are especially vulnerable to rapid price changes and/or volatility in prices as we've had over the last 18 months. This vulnerability flows from the nature of the cattle business:

1. *Long-term commitment.*—The keeping of a heifer to breed and produce a calf through feeding requires three years. Once the decision is made, there is little opportunity to alter the process without significant sacrifice.

2. *Perishable product.*—Beef can't be stored for lengthy periods. Once a calf is born, it goes to market 18 months later.

3. *Sells in competitive market.*—The cattleman sells in a purely competitive market in which supply and demand are absolute. He has no control over the price he receives.

4. *Buys in less competitive market.*—Except for feed products, the cattleman buys in a relatively less competitive market than he sells in. Most sellers have some control over supply and thus price.

5. *Infrequently in market.*—The cattleman is an infrequent participant in the market as either buyer or seller. He is therefore adversely affected by costs and prices fluctuating over short periods. Other producers who are in the markets continuously are able to average costs and prices and offset short-term volatility.

6. *Last place in credit market.*—Because of risks (weather, uncertainty of supply/demand factors, long-term commitment) cattlemen are considered relatively poor creditors. Profits tend to be low and volatile and so they are the first to feel credit rationing and/or high interest.

7. *Unable to pass on cost.*—While most suppliers to cattlemen can adjust prices immediately to reflect rising costs, cattlemen can't and must wait for long-term supply/demand adjustments.

8. *Illiquidity of cattlemen.*—While inflation may increase equity of cattlemen through higher land prices, it does not help in meeting cash flow because of slow adjustment in cattle prices relative to costs. Volatility in costs and prices adds to the problem.

9. *Tax credits and depreciation.*—Because prices do not reflect inflation as rapidly as costs, cattlemen are less profitable and less able to use tax credits. Also, they find depreciation of marginal cash value over short periods of time.

10. *Distortion of beef demand.*—Because of beef's place in consumption, inflation tends to lower spending on beef relative to other consumption (energy, interest, etc.) over short periods.

11. *Fixed assets.*—The cattlemen has little alternative use for his assets (basically land and cattle) other than producing beef over short periods. Much of his land has no other use than raising cattle. He can neither stop the process of cow to beef or significantly change the timing of producing beef. The value of his cattle assets typically reflect the market for beef more so than assets such as tractors used in other businesses. Thus neither additional borrowing or selling out is a good alternative during periods of stress.

12. *Foreign agriculture markets.*—Because of foreign restrictions imposed on importing U.S. beef, cattlemen infrequently benefit from foreign agricultural trade. They do, however, suffer the disadvantage of higher grain costs when exports deplete domestic grain stocks or lower cattle prices when U.S. imports of beef expand dramatically.

13. *Regulation.*—Cattlemen face a host of regulations impacting production (use of land and water, chemicals, transportation) and marketing (health and safety, grading, processing) that raise costs and discourage consumption.

14. *Government statements.*—Adverse comments about the health and safety of beef has raised unnecessary questions in the minds of consumers. Similarly, statements about the cattle industry concerning methods of production, use of new technologies and products, and treatment of land, water, and environment, have lowered the perception of cattlemen in the public's mind.

APPENDIX 2

Capital formation

One of the major problems facing this Nation today is the built-in bias in the tax structure against personal savings and business capital investment. The errors of focusing on taxing income and investment are evidenced by lack of productivity, heightened unemployment, raging inflation, unstable interest rates, and an alarming decline in the competitive world position of the U.S. industry and business.

Agriculture, and the livestock business in particular, in its modern-day capital-intensive position, shares heavily in the ills of discouraging capital formation through the tax system.

The National Cattlemen's Association strongly supports the President's proposal to cut taxes and to redirect the tax system toward encouraging capital formation and investment, as a part of his overall economic package to curb inflation and spur the economy.

President's tax cut proposal

The President's overall proposal calls for tax cuts in two stages. The first stage—currently being considered—consists of two basic elements only: (1) Tax cuts for businesses and individuals, and (2) Simplification and acceleration of depreciation (commonly known as "Capital cost recovery").

Individual income tax rates would be reduced 10 percent per year for 3 years, beginning July 1, 1981, (5 percent for calendar year 1981). Also, the top tax rate (70

percent) on unearned income would be phased out over 3 years, and the top rate on capital gains would be reduced from 28 percent to 20 percent.

The President's depreciation proposal follows the bill introduced during the previous Congress by Jones (D-OK) and Conable (R-NY), and is commonly known as the "10-5-3" proposal. Depreciable property would be grouped into 3 useful life categories—3, 5, and 10 years. Cattle and equipment would be in the 5 year category, cars and trucks—3 years, and structures—10 years.

In addition to faster write-offs (depreciation), investment credit would be increased to 5 percent for assets with useful life of 3-5 years and 10 percent for those with 5 years and over. NCA supports these efforts by the President.

The second stage of the President's tax proposal would include such reforms as indexing the tax system for inflation and amending the estate and gift tax provisions. NCA favors complete repeal of the latter, but has helped draft major amendments which would greatly help the orderly transfer of farm/ranch property from one generation to the next.

APPENDIX 3

Federal spending cuts

The National Cattlemen's Association strongly supports the President's proposal to cut spending substantially, as a part of his economic package to curb inflation and spur the economy.

Developments during this century are a sad commentary on the U.S. system of government, and raise the very pertinent question of whether or not we are capable of governing ourselves.

In 1973, the Congress started appropriating money for certain government functions which were excluded from the Federal budget. This was purely and simply a device to avoid the necessity for accounting for extra funds being spent and added to the Federal debt—an outrageous deception, to say the least.

Coming into this century, in the year 1900, Federal Government expenditures amounted to $521 million, and the Federal debt was $1.263 billion. By the end of World War I, annual outlays had increased to $18.492 billion and the Federal debt stood at $25.484 billion.

By 1929, annual outlays had been reduced to $3.127 billion and the debt had been paid down to $16.931 billion. From that time to the present, however, all figures have generally gone up, except for downward fluctuations in the late 1940's and 1950's.

The Federal Government spent its first $100 billion in 1962, at which time, the debt had reached $303.291 billion.

It took only 9 years (1971) to double the expenditures to $200 billion (debt, $409.467); and only 4 more years (1975) to go over $300 billion in Federal outlays—at which time the debt reached $544.131 billion.

By the end of fiscal year 1980, Federal expenditures were nearly double the 1975 outlay ($595.111 billion) and the debt rose 70 percent in that 5 year period to $922.232 billion. The debt ceiling has now been raised to $975 billion—almost 1 trillion dollars!!!

The annual Federal spending deficits are equally disconcerting. The following table shows the spending deficits (the amounts expenditures have exceeded tax and other income) for recent years, including the "off-budget" outlays:

	Billions
1976	$87.735
Transition quarter	14.513
1977	62.759
1978	71.287
1979	58.462
1980	83.260
1981 estimated	56.100

Note that the deficit figures in the table do not correspond to the deficits published by the Government because the published figures do not include the "off-budget" outlays.

President's proposed spending cuts

Fiscal year:	Billions
1981	$4.8
1982	41.4

Fiscal year:	Billions
1983	79.7
1986	123.7

NATIONAL EASTER SEAL SOCIETY,
Washington, D.C., April 7, 1981.

Hon. ROBERT J. DOLE,
Chairman, Senate Committee on Finance,
Washington, D.C.

DEAR MR. CHAIRMAN: I am writing with regard to the hearings that you recently held on the Administration's spending reduction proposals.

I respectfully request that this statement be included in the hearing record with respect to the hearings that your committee has been holding on this subject.

The National Easter Seal Society is the nation's oldest and largest voluntary health agency serving the disabled.

During the year 1981, Easter Seal Societies across the country will provide a comprehensive spectrum of services to more than 600,000 persons with disabilities. Easter Seal affiliates offer a wide variety of services to persons disabled from any cause. Our clients include victims of accidents, cerebral palsy, multiple sclerosis, blindness and the whole range of birth defects.

In addition to providing direct services, the Society benefits the entire disabled population of the nation by its legislative and other governmental activities. The organization is also substantially involved in public education and research designed to enhance the lives of people with disabilities.

In our dual role as a provider of rehabilitation services and as an advocate for individuals with disabilities, we have a substantial interest in the Medicare program, particularly as it relates to outpatient rehabilitation services.

We are opposed to the repeal of recently-enacted legislation which establishes outpatient rehabilitation centers as providers under Medicare.

Late last year, the Congress passed and President Carter signed the Reconciliation Act of 1980, Public Law 96-499. Section 933 of that Act recognizes outpatient rehabilitation facilities as providers under Medicare. The provision is effective on July 1, 1981. The effect of this provision is to make all of the services which these facilities provide, including physical therapy, occupational therapy, speech pathology services and respiratory therapy, reimbursable under Part B of the program.

The Reagan Administration's budget for fiscal year 1982 proposes repeal of this provision (and many other Medicare provisions which were contained in the Reconciliation Act). This position ignores the need for less costly ambulatory alternatives to hospital care.

Since the beginning of the Medicare program, all of these services have been covered under Part B when provided by hospitals, either on an inpatient or an outpatient basis. However, freestanding outpatient rehabilitation centers could receive Part B reimbursement only for physical and speech therapy services. This policy promoted the use of hospital-based services, dispite the fact that the services provided by freestanding centers are less costly and frequently more accessible than those provided by hospitals.

In the Reconciliation Act, the Congress acted to rectify this problem by allowing reimbursement under Part B for all comprehensive outpatient rehabilitation services, whether provided by a freestanding outpatient center or by a hospital. Section 933 does not add new benefits to Medicare but simply authorizes those benefits to be provided in another setting.

The provision in question was first proposed in the late 1960's. During several previous Congresses, it was included in legislation which was approved by one house but not the other. In 1978, for example, it passed the House almost unanimously as part of H.R. 13097, the Medicare Admendments of 1978, but died in the Senate because of the lateness of House passage. Enactment by the 96th Congress concluded a ten year effort by various national organizations, most notably the National Easter Seal Society, the National Association of Rehabilitation Facilities, the American Occupational Therapy Association and the American Association for Respiratory Therapy. Furthermore, the language of Section 933 was worked out over considerable time with a large number of people in the rehabilitation community to insure that the covered services were sufficiently defined and subject to adequate quality controls.

When Section 933 is implemented, many of your constitutents will have greater access to its benefits. In many cases, individuals who are being treated in a hospital will be able to receive these medical services in a freestanding outpatient clinic at a lower cost to the Medicare Trust Fund.

We, therefore, urge you to oppose any efforts to repeal this legislation.

Sincerely,

JOSEPH D. ROMER,
Director of Governmental Affairs.

STATEMENT BY DAVID J. STEINBERG, PRESIDENT, U.S. COUNCIL FOR AN OPEN WORLD ECONOMY

Statement submitted by David J. Steinberg, President, U.S. Council for an Open World Economy, to the Subcommittee on International Trade of the Senate Committee on Finance, in hearings on Fiscal 1982 budget authorizations for international-trade functions March 31, 1981.

(The U.S. Council for an Open World Economy is a private, nonprofit organization engaged in research and public education on the merits and problems of achieving an open international economic system in the overall public interest. The Council does not speak for any private interest or community of private interests. Its only standard is professional excellence and the totality of the national interest.)

Although the Council favors adequate appropriations for all the government operations covered by these hearings, this statement is limited to the International Trade Commission—specifically (1) the credibility and integrity of the import-relief proceedings, (2) the structure of the Commission (the number of Commissioners, etc.), and (3) the adequacy of ITC investigation and analysis in import-relief cases.

CREDIBILITY OF IMPORT-RELIEF "DUE PROCESS"

As the 96th Congress came to an end, the House Subcommittee on Trade, then the Ways and Means Committee, then the House of Representatives, and finally the Senate Finance Committee, all voted by huge majorities to empower (hence pressure) the President to negotiate an "orderly marketing agreement" restricting foreign exports of automobiles to the United States. Only the end-of-session logjam blocked final Senate action. Now the 97th Congress seems anxious to pick up where the 96th left off—this time through bills to impose quota limitations on imports of Japanese cars for several years.

These legislative maneuvers came soon after the International Trade Commission's 3-2 decision that imports were not a substantial cause or threat of serious injury to the U.S. automobile industry, hence that, under the criteria established by Congress, import restriction was not justifiable. No Congressional committee, nor (to my knowledge) any member of Congress, has faulted the Commission for any distortions of legislative standards or has documented any errors in its economic analysis. Careful examination of the ITC report in this case would show that, but for the minority's failure accurately to assess the cause of the rapid rise in auto imports, the decision to reject the import-control petition would have been unanimous.

Yet Congress seems ready to turn its back on the Commission for the decision reached in this case, indeed to give the back of its hand to orderly, objective "due process of law" in this area of trade policy. Such treatment of an ITC judgment which a Congressional majority may not find politically satisfying threatens the stature and the very integrity of the import-relief process that Congress itself took pains to establish. If Congress feels this way about import-relief judgments it chooses to reject without probing analysis, how much confidence and credibility remain for other proceedings and decisions (e.g., injury judgments in dumping and subsidy cases) which Congress has entrusted to the International Trade Commission?

If restriction of automobile imports gains majority support in the House and the Senate, this properly may be interpreted as reflecting Congressional feeling about the Commission and its judgment. The very future of the International Trade Commission is called into question. Whatever the import-relief standards established by Congress, ITC decisions in compliance with them should be respected by Congress until Congress decides to change the criteria or Congressional investigations reveal serious faults in the Commission's analysis and judgment in particular cases.

Congress created the Commission to remove government decisions in such matters from the political caldron. If Congress is now bent on putting these issues back into the political pot, it should terminate the Commission, saving the taxpayers millions of dollars every year even after whatever Commission functions are still considered essential are transferred to other agencies capable of handling them. In short, Congress should respect the Commission or as a sort of sacred cow, especially if it

treats politically controversial ITC decisions, reached in compliance with legislative standards, as just so much "bull".

THE STRUCTURE OF THE COMMISSION

The Commission has not had its statutory complement of six Commissioners for more than two years. President Carter's failure to appoint a sixth Commissioner during that period may say something about the White House view of the ITC during his Presidency. The fact that two Carter nominees for that post did not get far in the Senate confirmation process is no excuse for the empty seat. Congress itself seems not to care. Nor does any Congressional committee. Since the Commission seems to have got along reasonably well without a sixth Commissioner, why not terminate the sixth seat (as I asked in an earlier hearing of this subcommittee)? Is filling the fifth seat (recently vacant) really necessary? Congress should re-think the structure of the ITC and, at an appropriate time, the overall role of the Commission.

I question the automatic rotation of the Commission chairmanship. Each Commissioner is not ipso facto qualified to be head of the Commission. I also suggest that Congress look into the need for the personal professional staff each Commissioner is allowed to have even though the Commissioners have full access to the Commission's formidable legal and economic staffs. Is it possible that these private staffs have led to rivalries, including relationships with the main staff, that are less than desirable? Have these ramifications adversely affected the quality and utility of Commissioner opinions in import-relief and other cases?

SCOPE OF IMPORT-RELIEF INVESTIGATIONS

As I have argued in previous Congressional hearings, and most recently in testimony before the ITC in the automobile case, the Commission is not fulfilling its explicit and implicit obligations in import-relief investigations. The neglected provision of the current trade legislation is Section 201(b)(5) of the Trade Act of 1974. The Commission (a) is not fully assessing the adequacy of steps the affected U.S. industry has taken toward becoming more competitive with imports, and (b) is not assessing the extent to which government statutes and regulations may be impairing the industry's adjustment capability. Also neglected is assessment of the differential impacts which import restriction may have on different sectors of the industry. Windfall gains for some sectors that may not need government help may cause additional problems for those that do.

Not all these factors may materially affect the Commission's decision in every case, but all are important for the President to assess if he wishes to develop a coherent industry-adjustment policy whether or not the Commission finds serious injury or threat thereof, but particularly if it does. Such a strategy should be the framework for any resort to import control, and the trade law should so require. However, the President is free to proceed along these lines even without a legislative mandate, and the ITC should want to help him in every way it can.

STATEMENT BY THOMAS M. RUSSO, DIRECTOR, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, NEW JERSEY DEPARTMENT OF HUMAN SERVICES

SUMMARY OF PRINCIPAL POINTS

The Medicaid poor and needy require a program of full benefits for health care services.

The State of New Jersey is unable to provide full Medicaid benefits with the administration's proposed drastic spending reductions.

Many Medicaid persons will be seriously hurt and will face life threatening situations with the proposed Federal reductions.

A less severe and traumatic Medicaid reduction program should be followed by the Federal administration and legislature.

The "cry of the poor" must be heard and heeded for the ultimate benefit of the nation.

Mr. Chairman and Members of the Finance Committee of the U.S. Senate, I am Thomas M. Russo, Director of the Medicaid program in the State of New Jersey. Thank you for the opportunity to make this presentation concerning the administration's spending reduction proposals relative to the Title XIX Medicaid program.

Gentlemen, I am certain that you have heard the phrase and I quote "The Lord hears the cry of the poor. Blessed be the Lord." In the context of the hearing today, I might paraphrase that quote by saying "The Lord hears the cry of the poor. Blessed be those in the Congress who hear and heed this cry."

As the Director of the Medicaid program in one of the big ten Medicaid States, I know both personally and professionally of the tremendous need for and the good that the Medicaid program does for the poor, the elderly, the disabled, the blind, the needy and the children in the State of New Jersey. We all too often hear charges concerning waste, inefficiency, and fraud and abuse in the Medicaid program, often without ample supporting documentation to categorically uphold such allegations.

We all too seldom, however, hear about the tremendous benefits derived by our citizens because of the very existence of the Medicaid program. Very few people in high places, except when there may be a crisis such as the one I truly believe we are facing today, will or do recite the thousands of daily occurrences supported by Medicaid funds for our poor and needy people whose very lives and existence have been saved because they received the operation that was required, because they were able to obtain the expensive life sustaining drugs that are needed, because they could obtain renal dialysis services regularly, because prosthetic and orthotic devices and medical supplies were readily available to help them sustain themselves. In short, because there is a Medicaid program and a caring government that has recognized and provided for these needs for the millions of our citizens.

Many of these citizens, I might add, are the very ones who in the past have fought America's battle on foreign soil, who have provided the productive capacity that has helped to make America great and who have reared the generations of children who are now making America's basic decisions. The Congress cannot turn its back on these people and on those who in future generations America must in large part depend, these of course being the children of the poor and the needy.

There are those who say that the proposed reductions in funding for the Medicaid program will not hurt those who are truly in need. This I can assure you is not true. The needy will be hurt and in some cases will be hurt very badly, to the extent that their very existence may be in danger.

Based upon my current knowledge of the proposed Federal capping formula for the Medicaid program, the State of New Jersey will receive 2.86 percent of the total national funding for the Medicaid program. If the figure of 17.2 billion dollars at the national level for Fiscal Year 1982 is correct, this will mean that the State of New Jersey will be provided with 492 million dollars to run its Medicaid program for Fiscal Year 1982. That amount, standing alone, represents a potential loss of 37 million dollars in the amount of Federal money required to fund New Jersey's Medicaid program with its current benefit packages and reimbursement levels. Coupled with State-Federal matching funds, the reduction represents a potential loss of 74 million dollars in Fiscal Year 1982 for medical services, pending possible offsets from other programs that might affect Medicaid eligibility.

There are some areas in which a re-emphasized cost containment program can save some of this money without materially affecting benefit packages. However, gentlemen, I can assure you that those areas in an efficiently operated Medicaid program, such as that which exists in New Jersey, are very few without either reducing or eliminating reimbursement to providers or services to recipients. Even with absolute flexibility on the part of the State to operate its Medicaid program free from any Federal restraints, it is absolutely impossible to realize within one fiscal year a total saving equal to 74 million dollars without adversely affecting the health care of the needy and the poor. Of necessity, some programs must be sacrificed.

In this regard, there are no low priority services, nor are there optional services in the eyes of those for whom a previously available benefit has been curtailed, withdrawn or is no longer available. To obtain such a benefit once it has been eliminated, the Medicaid recipient must find the means to obtain that service from an already meager subsistence allowance. Such choices only make the poor poorer and the needy more needy.

I truly believe that the State of New Jersey and all the other states in this great nation are as interested as is the Federal Government in economy and efficient operation and in beating back the ravages of inflation. However, this should not be accomplished at the expense of those most needy in our society. A total Federal cap on expenditures at the State level should not be considered by the Congress at this time. At the most, a partial Federal cap, possibly at one half of the current proposed level or as proposed by the National Governors' Association, should be considered while at the same time giving the states the full flexibility that they need to independently operate their Medicaid programs and to initiate their own cost containment programs. Anything less, in my opinion, will leave totally unmet the full range of health care services required by our needy people.

Gentlemen, I could provide you with a litany and a list of those areas and items that should not be touched by the proposed capping program and could provide you with a similar enumeration of alternatives. However, many of those who are ap-

pearing at today's hearings are providing such documentation. My simple purpose is to urge that you not turn your back on the poor and the needy or the handicapped and on children by taking needed Medicaid money away from the States. Do not take medical and health care away from the sick. Give them the means to have their medical bills paid and to free their shoulders of this burden. I urge that you hear the cry of the Medicaid poor.

Thank you again for the opportunity to express these views on behalf of New Jersey's Medicaid program.

STATEMENT OF PROPOSED BUDGET AMENDMENTS BY COUNCIL OF HEALTH CENTERS

The members of the National Council of Health Centers would like to take this opportunity to offer our views on President Reagan's proposals for a program of economic recovery including revisions in the Medicaid program.

The National Council represents investor-owned multifacility nursing home firms which own or manage 130,000 nursing beds in 44 states. Our members also provide many other essential health services such as home health, meals on wheels, and adult day care.

The day following President Reagan's national address on the economy, the National Council sent the President a telegram of congratulations stating, "A restructuring of the financial supports of our health care system is long overdue."

During the past few years, the American public has been led to expect that the answers to their health and social problems are to be found primarily through government support and intervention. Once a particular course of action is followed for a number of years as has been the case in this instance, it is extremely difficult to change from that course. Public expectation, vested interests, and demands grow exponentially in direct correspondence to the expansion of the financial support available for a program. In the name of uniformity, individual initiative and private enterprise have been frowned upon and discouraged through the development of a myriad of inflexible federal standards. These standards in many instances do not relate to the direct delivery of patient care.

In the area of long term care, the New York Moreland Act Commission on Nursing Homes and Residential Facilities found that state and federal regulatory agencies, ". . . have not developed sensible and workable regulatory programs. Regulation has been piled upon regulation in bewildering detail, with little attempt made to determine which is essential and which is superfluous."

The new proposals offered by President Reagan offer fresh hope that we can break away from the reliance on a process of writing a new standard to correct the inherent deficiencies of the original standard rather than eliminating the original contingent cause. We suggest that solutions to the growing demand for services may indeed be found in the expanded application of the principles of the private marketplace and competition. We would propose that the long term health care sector of the health industry would be extremely conducive to develop the expansion on the principles of competition. We would submit that the forces of competition first, do function currently in regard to long term care services. Second, they may be able to function better and be implemented more quickly in that service area than the acute sector given the facts that: 1) the decision process may be more deliberative and can be made over a longer period of time and 2) there are a number of alternatives to select from among similar, yet distinctive, institutional and non-institutional services. As a result, an individual has the ability to make informed marketplace choices regarding his long term health care needs.

What is needed, therefore, is an effort to inform the prospective patient, family, and where applicable, the guardian of the various services, their cost, availability, benefits, quality, and other items which affect the provider's ability to meet the patient's needs. Indeed, we believe that there is already a highly competitive market for private pay patients in nursing homes and that the quality and scope of services have been greatly enhanced as a result.

We would strongly support the adoption by federal and state programs of the principles of competition for the Medicare and Medicaid programs and the incorporation of the same competitive purchasing practices for their clients as presently exist for private patients.

Long term care offers a unique set of problems, but those problems are not insurmountable. Their resolution will require fresh thinking and new approaches—several of which we will highlight later.

First, we would like to address the Administration's proposals for health budget revisions including the imposition of caps on increases in Medicaid expenditures.

While it is true that Medicaid nursing homes' expenditures have significantly increased over the last ten years, many factors have contributed to this rapid

growth including increases in life expectancy of the aged, increases in utilization, and minimum wage increases. It should be stressed that nursing homes have virtually no control over these factors. As a point in fact, the single greatest increase has been in the services for the mentally ill which have directly resulted from the federal government's policy of deinstitutionalization. For the most recent period of time that HCFA has published data (1976-78), Medicaid payments for services to the mentally ill increased 72.5 percent, 44.7 percent, and 53.6 percent; while those for SNFs increased 1.7 percent, 8.0 percent, and 19.2 percent. Between 1975 and 1978, total expenditures for all Medicaid nursing home patients increased from $4.3 billion to $6.2 billion, yet the average daily Medicaid rate has remained under $30.

Because Medcaid recipients account for over 50 percent of the patients in nursing homes, any cutbacks will be widespread and severely felt. Unfortunately, with respect to these patients, nursing homes do not have the latitude of a hospital's $200-250 daily rate within which to allocate any losses as a result of a cut in their payments. The average Medicaid nursing home reimbursement rate is between $20-30 per day, which covers the patient's room, three meals, laundry, 24-hour nursing care, activities, social services, and use of specialized consulting services such as dietitians, pharmacists, and medical directors in skilled nursing facilities.

Because of the necessity of protecting a facility's ability to meet the medical needs of its patients, which by definition and statute is the primary basis of an admission, the services most likely to first be affected by any cutbacks will be those which enhance the social aspects of the patients' lives such as activity programs. Thus, we would stress that while we are willing to do our part in absorbing a payment reduction, neither nursing homes nor their patients will be able to withstand deeper cuts if additional savings were determined to be necessary.

There is no doubt that our economy is in serious trouble and that extricating ourselves will require considerable sacrifice on everyone's part. For that reason, we can understand the necessity to consider such ideas as the President's proposed five percent general ceiling on increases in total Medicaid expenditures for fiscal year 1982 as an interim measure to later major revisions and improvements to our long term health care system. Acceptance of these caps, however, is conditional upon other program changes which can provide added savings and reduce inefficiencies.

Some of these essential modifications are: supplementation, reducing administrative costs, decreasing regulatory burdens, eliminating discriminatory practices against proprietary organizations, and practicing prudent buyer concepts by not paying significantly greater amounts to some providers for the same services provided by others at a lower rate (e.g., VA nursing homes, hospital-based SNFs, and publically-run nursing homes . . . these facilities should have to compete for the same rates or be closed down).

Finally, our acceptance of a cap and our willingness to make sacrifices is predicated upon the belief that these cuts will be made equally and will transcend all benefits and providers.

THE GOVERNORS' PROPOSAL

The National Governors Association has singled to nursing homes and has proposed that Medicaid nursing home expenditures be singled out for a cap within the long term care field.

The National Council is unequivocably opposed to this proposal!

First, this is exactly the kind of inequitable treatment of singling out one group over all others for cutbacks that President Reagan has promised to avoid. We would draw your attention to our earlier comments as to the causes for the increase in nursing home expenditures. It should also be noted that the General Accounting Office has said that hospital costs have risen faster than any other component of the health care system.

Further, it has been Medicare's costs that have increased the most, not Medicaid. Much of the blame for Medicare's increased expenditures can be directly attributed to two factors: (1) The program's retrospective cost reimbursement principles; and (2) the process mentioned earlier of adding one regulation after another to correct the inherent deficiency in the original standard.

The inflationary impact of these two factors on our health care system cannot be ignored. If the Federal and State government truly wish to get a handle on health care cost increases, then they should focus on Medicare, not Medicaid.

Second, it was precisely this same sort of cap which was proposed for hospitals by the Carter Administration and which was resoundingly defeated. The movement to defeat this legislation was spearheaded by former Congressman David Stockman, now Director of the Office of Management and Budget.

Third, the Medicaid payment system already gives States more latitude to control rates for nursing homes than for any other provider group. In addition, Federal

statute specifically provides the States with the flexibility to adjust not only their rates, but also any of their Medicaid program or eligibility requirements where they supercede Federal standards. Thus, the nursing facilities need not shoulder the entire burden of any reduction.

Fourth, as has been pointed out in previous testimony before this committee, mandatory ceilings have a documented tendency to become floors. In so doing, they become self-defeating and eliminate one of the stated goals of both the National Governors Association and the Administration, instilling flexibility and innovation into the administration and provision of Medicaid services.

And again, as pointed out earlier, the majority of cost increases experienced by nursing homes are beyond their control which is why a cap on only the nursing home portion of Medicaid expenditures cannot succeed in holding down total costs of the program.

HEALTH PLANNING

The National Council supports the Administration's proposal to phase out Federal expenditures for health planning. We firmly believe that the certificate of need program has not only been costly, it has also created a serious shortage of nursing home beds across the country. The difficulty and length of time required to obtain a certificate of need has served to discourage capital investment and financing of needed long term care beds. As a consequence, the U.S. is now spending over one billion dollars a year for Medicare and Medicaid patients who are in hospitals awaiting placement in nursing homes.

In September 1980, the American Association of Professional Standards Review Organizations conducted a one-day study of the number of patients in hospitals awaiting placement. Their survey covered only 4,131 of the 5,923 acute care hospitals and found 17,783 such patients. Most hospitals are being reimbursed their full rate for these patients, who really require the less intense and less costly services of a nursing home. It is both ironic and sad that we are paying so many millions of dollars for these unnecessary stays yet the patients are not even getting the services they need because acute hospitals are not equipped to serve the long term care patients. Unlike nursing homes, they do not have activities programs with special rooms set aside for them nor dining rooms where patients may eat. Many are not prepared or able to offer the special rehabilitative therapies required, such as physical, occupational, or speech therapies.

While there are additional reasons for this hospital "backlog" [1] health planning is in large measure responsible for this unnecessary burden which is being placed on our health care system. When one considers the elderly population explosion we are experiencing, health planners have been myopic and costly and have become part of the problem, rather than the solution.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The National Council is supportive of the elimination of Professional Standards Review Organizations as a federal program which has not proven cost effective. Those PSROs which have gone beyond utilization review activities to look at nursing home quality have duplicated the efforts and conflicted with the existing state survey and program review activities. The experience of our members with staff of individual PSROs has generally been negative. We do not believe the diagnosis and treatment of elderly patients can be categorized, numbered, and fit into neat little boxes on a reviewer's chart. PSROs have become the intermediaries but without exhibiting any flexibility in carrying out their tasks.

Our most serious concern if PSROs were to be eliminated relates to the problem outlined earlier . . . the identification of patients in hospitals who need nursing home beds. We feel that it is vital that the utilization review activity in hospitals and nursing homes be revitalized and retained, particularly while there is still the incentive for the hospital to keep these patients.

NEW PAYMENT SYSTEM

We believe that significant savings can be achieved by changing Medicare's SNF reimbursement to a prospective payment system. The savings would come by making Medicare more attractive to nursing home providers, thus inducing them to participate in the program. As a result, the thousands of patients who have been

[1] For example, there is presently no incentive for hospitals to dicharge these patients; Medicare eligibility for skilled nursing is so strictly defined that scarcely 3 percent of the nursing home patients qualify; Medicaid reimbursement is below the nursing home costs, thus heavy care patients are extremely difficult to place as the cost of their care is even higher.

documented in hospitals as awaiting placement in nursing home beds would be greatly reduced. The Medicare/Medicaid programs are spending nearly $1 billion each year for expensive and unnecessary hospitalization of patients needing a lower level of care.

In September 1980, the American Association of Professional Standards Review Organizations conducted a one-day study of the number of patients in hospitals awaiting skilled nursing placement. Their survey covered only 4,131 of the approximately 7,000 acute care hospitals and found 17,783 such patients. Most hospitals are being reimbursed their full per diem rate for these patients, who really require the less intense and less costly services of a nursing home. It is both ironic and sad that we are paying so many millions of dollars for these unnecessary stays, yet the patients are not even getting the services they need because acute hospitals are not equipped to serve the long term care patients. For example, unlike nursing homes they do not have programs for assisting long term care patients in their social activities of daily living, nor the special rooms equipped and set aside for them. Many are also not prepared or able to offer the special rehabilitative therapies required such as occupational or speech therapies.

We believe that a prospective reimbursement system is inherently less difficult to implement in nursing homes than in hospitals. Items of service, personnel needs, equipment, and plant requirements are much easier to forecast and to control. The accounting systems are also less complicated and are easier to adapt to the requirements of a federal program since the vast majority of the patients are supported through Medicare and Medicaid.

Furthermore, the National Council would like to see a move away from allowing a profit to be based only on a return on an owner's net equity as prescribed in the Medicare program. Equity is not an appropriate basis to determine if a nursing home is doing a good job. Instead, the National Council would propose an incentive return for both proprietary and nonprofit facilities based on the quality of the patient care and the efficient management of the facility.

Both proprietary and nonprofit facilities should not be guaranteed that the government will pay their full costs plus a growth allowance for nonprofit facilities or profit for proprietary facilities. Instead, the payment system should provide the opportunity for a return for all types of facilities if they provide services efficiently and in conformity with the applicable federal and state regulations.

Inefficient providers should no longer be subsidized by government funds. There is no reason that we should pay hospital-based SNFs $90–100 per day or public facilities $50 per day for the same services that freestanding SNFs are providing for $30-35 per day.

The National Council suggests that the introduction of elements of competition which have functioned so effectively in the private pay sector may work equally well for Medicare. Just as the prudent buyer concept seeks the most efficient providers or suppliers, so should Medicare nursing home reimbursement principles be based on rewarding efficiency and quality.

ELIMINATION OF THREE-DAY REQUIRED HOSPITALIZATION FOR MEDICARE SKILLED NURSING BENEFITS

Last fall, as part of the Onmibus Reconciliation Act, the Congress approved a provision eliminating the requirement for a prior three-day hospitalization in order to be eligible for Medicare home health benefits. At that time, the National Council testified that this same requirement should also be eliminated for skilled nursing facilities as it constituted an unnecessary and unfair barrier in the Medicare program.

We again urge your consideration of the elimination of this costly and unnecessary requirement.

There is no logical reason why an elderly person who otherwise meets the Medicare criteria for a skilled patient should be denied skilled nursing facility benefits merely because he has not been hospitalized. Fears that elimination of this provision would lead to great cost increases are unfounded. A demonstration project conducted in two states under contract to HHS (then HEW, 1978-1979) found little increase in program costs or utilization. Many of the patients were terminal cancer patients who had remained in their homes but needed more nursing services during their last few days. They did not need to be hospitalized. Yet Medicare eligibility requirements would have forced them into a hospital were they, no doubt, would have spent their remaining few days or weeks rather than in a less costly and less intensive care skilled nursing facility.

A 1976 HEW report, Forward Plan for Health, endorsed elimination of the three-day stay stating, ". . . Experience suggests that significant numbers of Medicare beneficiaries are now receiving hospital care would benefit as much from SNF

care . . ." and " . . . It is probable that patients in need of only skilled nursing care and who are now instead hospitalized are never subsequently transferred to an SNF because of paper (eg, transfer of medical records, treatment plan) and the lack of any financial incentive or disincentives (eg, no cost sharing is required after first hospital day and until the 61st day)."

In discussing potential savings, the Foward Plan for Health goes on to say, "Since the average Medicare cost of a covered day in an SNF is less than one-third the routine cost per day in a hospital, the potential cost savings is obvious."

The savings in eliminating these unnecessary hospitalizations are too easily dismissed by many individuals. Even eliminating a relatively few number of such visits could have a significant impact in terms of increased benefits for patients. The funds used to keep a patient in a hospital for three days would pay for 20 days in a skilled nursing facility. Considering that the average length of stay as a skilled Medicare patient in a nursing home in 1979 was 24 days, the benefits of such a trade-off are obvious. Further, with no incentive for the hospital to discharge the patient to a less costly level of care, the advantages of direct placement of the patient at the level of care appropriate to his needs are quite apparent.

While we realize that funds are limited for Medicare program improvements, we believe that in eliminating the three-day stay requirements the savings in decreased hospitalization will more than offset any additional program costs.

ADMINISTRATIVE CIVIL PENALTIES FOR FRAUDULENT MEDICARE/MEDICAID COSTS

During the previous Administration, authority was being sought from Congress for HHS to impose financial penalties on providers determined by the Department of HHS to have submitted fraudulent claims under Medicare or Medicaid. We have been informed that the Department of HHS may again seek this authority by proposing similar legislation.

We have serious reservations about this proposal, not the least of which is that it would circumvent the judicial process and establish an administrative review in which the Department would become prosecutor, judge, and jury. This is an extremely dangerous precedent in what constitutes a determination of a provider's culpability in acts which by statutory definition are criminal acts for which the accused is constitutionally entitled to a formal trial to determine that person's innocence or guilt. An administrative review before a board that is a part of the complainant's agency does not meet the rights set forth under Article III, Fifth, Sixth, and Seventh Amendments of the Constitution.

We believe that there will never be sufficient safeguards when the agency responsible for writing, interpreting, and administering the law also sits as the judge. This is especially disturbing in the context of a program of this size and complexity, particularly given the constant confusion and uncertainty regarding interpretations of regulations. Furthermore, it is important to note that there have been numerous court decisions which have found that it is frequently a question of whether the program itself contributes to this confusion.

Secondly, there is no doubt that the authority which would be conferred upon the Secretary in such a proposal would duplicate already existing provisions which were passed as part of the Medicare/Medicaid Anti-Fraud and Abuse Act as well as Section 916 of the Omnibus Budget Reconciliation Act of 1980. What the proposal does, in fact, is to allow the Secretary to duplicate, at an administrative level, sanctions which should only be imposed after proper adjudication of fault by the courts. We find no evidence that the Secretary needs this authority nor do we believe Congress should make it easier for the Secretary to impose financial penalties.

In continuing to advocate this proposal, it seems that HHS has chosen the path of administrative expediency over the traditional constitutional protections of due process and impartial trial by jury. The National Council cannot support any legislation which would relegate the finding of wrongdoing to an administrative level.

We do not believe that Congress would wish for any agency to have the broad sweeping authority which would be afforded HHS in this proposal. The issues it raises are much too important to be decided administratively and would, we believe, be a serious deprivation of rights afforded to everyone under the previously cited Article and Amendments to the Constitution.

SURVEY/CERTIFICATION

The Department of Health and Human Services has under consideration major changes in the federal survey/certification requirements for providers.

We support a number of these changes and believe they will not only lead to significant program savings but will have a positive impact on the quality of care. The proposals include a modification in the annual survey process so that providers who do well in their facility surveys are reviewed on an 18 month or 2 year basis rather than annually. Further, the repetitive review of structural items which do not change year after year may be eliminated. The National Council has suggested many times in testimony before Congress and HHS that this was an unnecessary waste of valuable surveyor time.

We have also noted that federal standards for nursing homes unnecessarily focus too heavily on the credentials or years of experience of each and every staff member as well as committee meetings, minutes, and bylaws. Rather, we believe that the emphasis should be on the patients and on the quality of care they are receiving.

In short, we are encouraged by the efforts currently being considered by HHS and propose that those efforts be part of an ongoing process with further modifications focused on decreasing the unnecessary paperwork burden. Paperwork and reporting requirements add many dollars to the cost of nursing home care while at the same time detract from that care by taking scarce staff time away from the patient. This we believe is an example of misplaced priorities.

The National Council proposes as an additional cost savings measure, that Congress and HHS consider the granting of deemed status to skilled nursing homes in the Medicare program that have received accreditation from the Joint Commission on Accreditation of Hospitals (JCAH).

For a number of years JCAH has surveyed nursing homes, independent of the state and federal survey process. JCAH surveys are thorough and effective and should be permitted to take the place of the federal and state surveys rather than duplicating that effort.

Nursing homes should be afforded the same opportunity as hospitals in being granted deemed status. In many ways, the JCAH survey is superior to the federal and state surveys as it places great emphasis on quality factors and the care that the patient receives. Additionally, JCAH strongly believes in its role as a consultant/advisor to nursing homes . . . a role that we greatly support and endorse.

We urge the committee to consider implementing this approach for facilities and believe that significant cost savings could be achieved as a result, through reduced survey expenditures which are currently federally funded.

LONG TERM CARE IN THE FUTURE

There is no doubt that we will need to make some far-reaching changes in our long term health care system within the next few years and time is running out. The number of Americans over age 65 is expected to increase from 24.1 million in 1980 to 51 million by 2050. According to a 1980 Rand Corporation survey, persons over 65 will make up more than 12 percent of the population by the end of this century, and almost half of those individuals will be over 75 years old.

With current demand for long term care services exceeding supply, we will need to draw on every available resource, including the family, to provide the care or to supplement its cost. In 1978, the Congressional Budget Office estimated that there were 2.88 million severely impaired individuals who should be receiving nursing home services but were not. Dorothy Rice, Director of the National Center for Health Statistics, has recently estimated that 3 million more nursing home beds will be needed by 2003 to serve the needs of the elderly.

We recognize that the government is faced with growing budget limitations which will become even more severe as the number of elderly increases and the younger population who will have to support them shrinks. Thus, we must move to a pluralistic financial support system that encourages competition, private investment, and free entrprise. We must seriously consider additional funding and delivery models such as family responsibility, family supplementation, private insurance for long term care, and HMOs for long term care.

We believe that significant cost savings and efficiencies can be gained through a variety of such approaches. As an example, in 1976 when the federal government ended the practice of allowing supplementation, Tennessee's intermediate care facility budget increased by 28 percent. Relatives of nursing home patients had been allowed to pay a determined amount to the facility for the Medicaid patient's care. The National Council supports the reinstitution of supplementation as a means of alleviating some of the Medicaid burden and providing needed services to nursing home patients.

Inefficient providers should not continue to be subsidized by government funds. There is no reason that we should pay hospital-based SNFs $90–100 per day for the same services that free-standing SNFs receive $30–35 per day. Nor should county-run facilities receive $50 per day for those services.

Government programs should concentrate their scarce resources on providing the four fundamental long term care services to the truly financially destitute: (1) physician services; (2) nursing home care; (3) home health services; and (4) pharmaceuticals. Supplementation and copayments could defray some of the costs of these programs so that quality would not suffer in the face of diminished public funds.

We firmly believe that we should not be fostering programs that predicate themselves on the mandated economic dependence of their beneficiaries on the vagaries of government program policies and funding. In effect, the current approach to providing for the long term health care needs of our nation's elderly requires that they divest themselves of their assets and become wards of the state. That is the fallacy of the welfare approach and we vehemently object to it.

We would propose that we start, first, with the immediate steps suggested by President Reagan on February 18th, and, second, that we establish a national policy for long term care. We believe that competition can and must play an important role in a national policy for long term care. There are a number of ways of instilling competition at the consumer's point of purchase, such as the use of vouchers. Third, we feel it is extremely important to restructure the financial support of long term care into a more pluralistic system by looking at innovative and imaginative concepts such as:

Tax incentives to encourage the development of private insurance plans for long term care, including coverage of supplemental payments and coinsurance premiums.

Inheritance tax policies which recognize individuals' financial commitments and responsibilities in providing for the care of their elderly family members in their homes and appropriate health centers.

Establishment of self-help programs such as subsidized reverse mortgages in which individuals could borrow on the equity in their residence to assist in the payment for their long term health care costs rather than being required to dispose of their residence in order to qualify for any medical assistance.

Taxing programs with revenues being totally dedicated to long term health care for the elderly such as excise taxes on liquor and cigarettes.

Tax credits recognizing the fees of condominiums dedicated to congregate living under life health care plans.

These items are based on the thesis of preserving and vesting in individuals the financial ability to decide on the services that they wish to purchase within certain general guidelines. This is a reversal of the existing philosophy of the Medicaid program which is based on the elderly divesting themselves of their assets and becoming passive subjects in a government agency's decision as to the appropriate purchase of services. It is our opinion that the former concept is much more in keeping with the elderly maintaining their dignity and independence . . . a public policy objective that must be paramount in our society whose population percentage-wise is growing older.

The National Council has embarked upon a project to examine these approaches and to address the policy implications therein. Consideration will be given to the many funding and service models which can and must be incorporated into the resulting proposal. We would appreciate the opportunity to discuss the project and our findings with members of the Committee once the project is completed.

We appreciate this opportunity to submit our comments on the budget reductions being considered at this time by the committee.

Testimony by Alice Sporar, National Spinal Cord Injury Foundation

My name is Alice Sporar. I have been disabled as a result of polio since 1949. For the past ten years, I have been involved with the National Spinal Cord Injury Foundation.

During this time, I have seen positive changes in attitudes toward disabled people due to legislation, such as, the Rehabilitation Act of 1973, especially Sections 501, 502, 503, 504, the 1978 Amendments to the Rehabilitation Act, especially Title VII Independent Living, the Education for All Handicapped Children Act of 1975, and the newest 1980 Social Security Amendments. As a result, more disabled people are completing high school, graduating from college, and holding responsible positions.

Federally funded independent living centers are the result of the 1978 Amendments to the Rehabilitation Act of 1973. The Northeast Ohio Chapter of National Spinal Cord Injury Foundation has developed one of these centers, Services for Independent Living, which is completing its first year. The centers are funded for three one year contracts by Rehabilitation Services Administration through the State Rehabilitation Services Commission. During this time, it is expected that the centers will have been able to tap local funding sources for continuing support. The

goal of Services for Independent Living and other centers throughout the country is to maximize the independent living skills of disabled people and allow them to become contributing members of society through programs of peer support, housing and attendant referral, and advocacy. The centers are managed and operated by disabled people. Services for Independent Living is directed by a woman paralyzed from the neck down who had not been employed since her accident twenty-five years ago.

In Ohio, disabled citizens are working toward developing an in-home attendant care program. The program will provide attendant care for severely disabled persons in their homes vs. institutionalization. This would allow disabled individuals to be employed, thus becoming taxpayers. In-home attendant care programs have proven to be cost effective in California and Massachusetts. In-home attendant care is one of the programs being developed by the federally funded independent living centers.

We understand that the Reagan Administration plans to repeal all of the Rehabilitation Act except Sections 501, 503, and 504. This means Title VII—Independent Living Centers would be eliminated. Cutting funds for Independent Living, Vocational Rehabilitation, the Education for All Handicapped Children Act of 1975, the Social Security Amendments of 1980, which remove work disincentives, and Section 502 of the Rehabilitation Act, is a fall back into the Dark Ages. We do not want to see Rehabilitation and Independent Living put into a block grant with Social Service. Social Service stresses dependence. Rehabilitation and Independent Living stress independence. These programs which the Reagan Administration plans to eliminate are the ones needed to keep disabled people off of welfare rolls and allow them the opportunity to be employed and to contribute to society.

We do not want to lose all we've gained over the past ten years. We must preserve the Rehabilitation Act of 1973, the 1978 Amendments, especially Title VII—Independent Living Centers, funding for Vocational Rehabilitation, the Education for All Handicapped Children Act of 1975, and the 1980 Social Security Amendments. If the regulations are too complex and costly, then they can be amended, but we must not eliminate entire laws.

It's ironic that this testimony is necessary in 1981, the International Year of Disabled Persons.

STATEMENT OF JAMES ALLEN COX, JR.

Mr. Chairman, this statement is submitted by the National Association of Rehabilitation Facilities relative to your current hearings on the Administration's spending reduction proposals. The Association is the principal national organization of rehabilitation facilities. Our membership includes over 800 medical and vocational rehabilitation facilities. Because of pressure of the Committee's hearing schedule we have not requested time during the hearings, but wish to have this statement considered by the Committee and included in the record.

We wish to call your attention to two proposals of the Administration which are counterproductive to the expressed goals of the President's program and, we believe, conceived without a full recognition of their effect. It is hoped that the Congress in its deliberations will render its own judgement on these items.

The first of the two is the proposal to repeal the recently enacted provision of the Medicare Act to qualify outpatient rehabilitation facilities as providers under the Medicare program and to cover the services they provide to Medicare beneficiaries. This provision was enacted as Section 933 of the Reconciliation Act of 1980, only four months ago. The language of the provision was drawn from a bill introduced by Senator Ribicoff with the Chairman of this Committee as a cosponsor.

The Administration's Budget proposes repeal of this legislation, but with no analysis or justification. The Budget justification prepared by the Department of Health and Human Services does not address this item at all except to dismiss it along with a variety of other provisions included in the Reconciliation Act, as "low-priority benefit expansions." The Congress enacted this legislation to eliminate a gross inequity in the Medicare program, both for comprehensive rehabilitation facilities and beneficiaries, and to provide for the receipt of comprehensive outpatient services in less costly settings than is now the case.

Presently, Medicare covers comprehensive outpatient services when rendered by a hospital. This has been the law since the inception of the Medicare program in 1965. Outpatient rehabilitation coverage is not a new benefit; it is as old as the Medicare program. The change made by the Congress in the enactment of Section 933 was not to add a benefit to the program, but rather to make it possible for Medicare beneficiaries to receive the same allowed services in a different medical setting. Section 933 is to become effective on July 1, 1981. At that time Medicare patients

will be able to receive comprehensive rehabilitation services from outpatient centers—many associated with the Easter Seals organization—these will be covered under Part B.

If this provision is not implemented, Medicare patients can still receive the same services in hospitals, generally at higher costs. The effect is to discriminate against fully accredited comprehensive outpatient rehabilitation facilities, often more accessible to patients and certainly equally competent. More importantly it would discriminate among beneficiaries in terms of their access to hospital and outpatient centers. The Budget estimates that repeal of this provision will "save" a negligible sum in the current fiscal year and $13 million in fiscal 1982. This ignores the fact that patients can go to a hospital for exactly the same services and that any "savings" are therefore illusory. Moreover, there is a tendency for patients to remain in hospitals as inpatients if Medicare does not provide for outpatient coverage through facilities accessible to them. This is certainly the case for the older people covered by Medicare who typically suffer from stroke, arthritis, and similar debilitating conditions.

Mr. Chairman, these facts were recognized by the Congress last year when it passed the law (P.L. 96-499). Now it is proposed that this sensible action be reversed, not because of some analysis of rehabilitation and its costs and benefits, but rather because it is a small provision which is vulnerable to offhand dismissal. Repeal of this provision will not save any money. It will, we believe, cost the Medicare Trust Fund money by promoting inpatient care and the use of hospitals for outpatient service.

We ask that in your hearings these facts be explored with the Administration's witnesses. You will find that there is no rational basis for repeal of outpatient medical rehabilitation coverage even under the most stringent of fiscal conditions, unless it is also proposed to repeal coverage for the same services when rendered by hospitals. This is not the case, nor should it be.

Secondly, we wish to call to your attention the proposal to eliminate the Beneficiary Rehabilitation Program for Social Security Disability Insurance beneficiaries. The Administration's proposal is to eliminate $87 million which was budgeted for this program in 1982.

Under the BRP, Social Security Test Funds are used to rehabilitate people receiving Social Security by reason of disability with the objective of restoring them to gainful employment and getting them off the Social Security roles. This program has received some criticism in recent years because of differing data about its costs and benefits, but all of the analyses done of the program, including studies by GAO and the Rehabilitation Services Administration, agree that it is cost beneficial. For every dollar spent there is substantially more than a dollar saved in terminated cash assistance. The most critical study on the program done by GAO found that the cost/benefit ratio was 1:1.5, that is, for every dollar spent, the government saved $1.15 in benefits which would otherwise have been paid. Other studies done by RSA have indicated much higher cost benefit ratios.

In 1979, at the direction of the Congress, the Social Security Administration began to reallocate these funds to states which showed the best track records in the rehabilitation of SSDI recipients. There is little experience under this system, but it can only improve the results which were already sufficient to justify this program. The HHS budget justification indicates that services will be provided to the same people from the social services block grant which is proposed to meet a large number of needs with only 75 percent of current funding. The emphasis here is benefits payments rather than removing beneficiaries from the SSDI by restoring them thru rehabilitation—as the designated Beneficiary Rehabilitation Program does. And, again, the government will be the loser by continuing to pay out social security benefits.

Mr. Chairman, these proposals have not considered the detrimental impact on a program which is cost effective and constructive, not welfare. They will increase dependence and government spending.

We urge the Committee to retain the Beneficiary Rehabilitation Program.

STATEMENT BY JOHN J. HOULIHAN, PRESIDENT, AMERICAN DENTAL ASSOCIATION

Hon. JOHN H. CHAFEE,
Chairman, Subcommittee on Savings, Pensions, and Investment Policy, Senate Finance Committee, Washington, D.C.

DEAR SENATOR CHAFEE: The American Dental Association appreciates this opportunity to present its views on S. 243, the Savings and Retirement Income Incentive Act of 1981 and other tax legislation designed to encourage long-term individual savings and capital investment.

As you are aware, this proposed legislation would expand eligibility for participation in individual retirement account plans (IRAs), increase the maximum tax deductible contribution IRA limits, and make other equitable changes to encourage participation in IRA retirement programs.

However, as presently drafted, the proposed legislation omits any reference to making similar equitable changes to encourage participation in retirement programs for self-employed individuals and their employees, commonly referred to as H.R. 10 or Keogh plans.

On behalf of the 130,000 dentists of our Nation, the Association would strongly recommend that the proposed legislation be amended to include provisions designed to encourage participation in self-employed individual retirement plans.

Under existing qualified Keogh retirement plans, self-employed individuals and their employees are severely discriminated against by overlapping special limitations and restrictions which are no longer necessary in light of comprehensive requirements established by the Employee Retirement Income Security Act (ERISA) of 1974. These restrictions relate to coverage, vesting, fiduciary responsibility, prohibited transactions, benefits, and limits on tax deductible contributions.

As a result of these restrictions relating to H.R. 10 plans especially when compared to comparable corporate pension plans, many self-employed individuals have been induced to incorporate their practices to gain tax advantages. The Association has no objection to dentists incorporating their practices, however, the Association is convinced that many dentists would not consider incorporating their practices if they would obtain tax treatment of retirement benefits as self-employed persons reasonably similar to those available to corporate entities.

Thus, the elimination of these special H.R. 10 limitations and restrictions would promote the goal of equity of tax treatment for similarly situated individuals. In addition, it would also discourage the present trend of encouraging self-employed persons to incorporate, and thereby, avoid these restrictions.

Moreover, elimination of the Keogh restrictions would result in a major simplification of the present tax laws, while extending coverage of the private pension system to many lower-income employees not presently protected.

At the very minimum, the Association would strongly urge that the present $7,500 limit on deductible contributions by self-employed individuals should be increased to $12,500 to reflect the cost of living increases that have occurred since 1974 when Congress last adjusted the present limit because of inflationary increases based on the Consumer Index to protect the retirement funds of self-employed persons and their employees.

Since the enactment of the Self-Employed Individuals Tax Retirement Act of 1962, Congress has adjusted the maximum deductible contribution limits on two occasions to reflect subsequent inflationary increases based on the Consumer Price Index to protect the retirement funds of self-employed persons and their employees.

The Association would also recommend consideration of a provision that would allow self-employed individuals to act as their own trustees of their Keogh plans. Such a proposed change would be consistent with possible trustee arrangements under other pension plans covered by ERISA.

Mr. Chairman, the dental profession is supportive of your subcommittee's efforts to adopt legislation designed to encourage long-term savings, to promote capital formation, and to protect retirement plans from the adverse effects of inflation.

It is our hope that you and your subcommittee will apply these worthwhile public policy principles not only to individual retirement account (IRA) participants, but also to self-employed individuals and their employees, who are presently subject to unnecessary restrictions and limitations that have inhibited their participation in retirement plans that would promote the same goals of encouraging long-term savings and formation of capital for investment.

The Association appreciates your consideration of our comments, and urges Congress to act on these recommendations at the earliest possible opportunity.

Statement of the Air Transport Association of America

The Air Transport Association is pleased to submit the airline industry's views on tax and spending reduction proposals in the Administration's program for economic recovery. The airlines believe that an improved investment climate is essential to reduce inflation, increase productivity, create jobs, improve energy efficiency, and improve our ability to compete in the international marketplace. The questions you are considering—the timing, nature and long run structuring of expenditures and tax legislation—are crucial to the efforts to restore strong economic growth.

The U.S. air transportation system interacts with the nation it serves on several levels: as a supplier of services that reduce production and distribution costs and

stimulate market development; as a supplier of public service that uniquely meets the requirements of the travel market for expedited and reliable transportation; and as a market for products of U.S. high technology industries, which, in part, enables the U.S. aircraft industry to maintain a position of supremacy in the world market. This system produces substantial benefits—benefits that will be lost if the growth and productivity of air transportation is curtailed or reversed. The nation more than ever requires a fast, frequent and reliable air transportation system, and the airlines must invest many billions of dollars to insure that this national need is met.

Recognizing the importance of air transportation to the nation's economy, there are three principal areas of the Administration's program for economic recovery where the airlines would like to provide comments and views: (1) Taxes on the transportation of persons and property by air—the area that relates to the airport and airways development program and the trust fund provided for it; (2) The need for effective capital recovery and related investment incentive legislation; and (3) Federal border crossing requirements imposed on international air commerce.

TAXES ON THE TRANSPORTATION OF PERSONS AND PROPERTY BY AIR

An area of concern to the airlines is the level of taxes to be imposed on the transportation of persons and property with regard to the Airport and Airway Development Program and the related Trust Fund. Congress has begun its deliberation and the Administration has submitted its specific recommendations for this important issue, including recommendations for program and tax levels.

On February 25, 1981, Mr. Paul R. Ignatius, President of the Air Transport Association, testified before the Senate Aviation Subcommittee on Commerce, Science and Transportation on reauthorizaton of the Airport and Airway Development Act. Under consideration at that time was Senate Bill S. 508 reauthorizing the important Airport and Airway Development Act of 1970 which had elapsed October 1, 1980. In the testimony, ATA provided estimated program costs for FAA budgets through 1985, including ADAP, facilities and equipment, research and development, and operations and maintenance. The ADAP estimates assumed that the larger airports in the U.S. would not be defederalized, thus the necessary expenditures would be larger than otherwise. All other program levels were the same as contained in S. 508.

Using the above assumptions, the ATA testimony demonstrated that it would be possible to maintain passenger and shipper tax levels in the future at 3 percent domestic, 2 percent air waybill, and $2.00 international departure charge, and still retain a surplus in the Trust Fund of over $500 million at the end of fiscal year 1985. Of course, if the larger airports were defederalized, the required ADAP amounts would be less and, therefore, the tax levels could be even lower.

Since the February 25, 1981 testimony, the Administration has revealed its recommendations regarding the FAA budgets for 1981 and 1982. Two principal characteristics of the Administration's proposals are as follows: (1) Supporting defederalization, the Administration would markedly reduce ADAP levels proposed earlier and place them at the $450 million level in fiscal year 1982; and (2) The Administration has proposed a sharp increase in the operations and maintenance levels taken from the Trust Fund, raising them from a 1981 estimate of $525 million to a fiscal year 1982 estimate of $1.950 billion.

Having provided the Senate Aviation Subcommittee with the airline industry's views on S. 508 and the commensurate funding and tax levels that might be appropriate, we would also like to provide an evaluation of the Administration's proposals on future FAA budgets.

The airline industry believes that the Administration's proposal to establish an airport and airway system where users pay their fair share of system costs is a good one. Each user should pay an allocated cost of the use of the system now and in the future. The future taxes imposed on the airlines and their passengers and shippers should be only as high as they need to be to fund the established program, while at the same time reducing the very large uncommitted surplus in the trust fund.

Comprehensive government studies have been completed on financing the airport and airway system and the percentage of user costs that should be allocated and recovered from each user. When these percentage shares are applied to the Administration's proposed fiscal year 1982 FAA budget, the allocated cost to the airlines would be approximately $1.4 billion. This amount could be recovered in fical year 1982 with less than the 6.5 percent ticket tax proposed by the Administration. Recognizing that airline passengers and shippers have contributed 93 percent of the surplus in the Trust fund, it should be drawn down over the next several years to at least a $500 million level from its 1980 level of $3.7 billion. Were that to occur, a ticket tax level of 3 percent could cover the FAA's allocated share of the cost of the

airport/airway system to the commercial airlines. Of course, it is proposed under defederalization that certain airports would gain authority to impose local taxes and charges to replace former ADAP funding. Under this proposal airline passengers would face a continuation of a federal ticket tax plus a local head tax.

We are in strong support of the Administration's position to implement a system of users paying their allocated share of the airport and airway costs. Based on recent comprehensive government studies, reliable information exists on allocation of the fair share of cost of the use of the airport/airway system. If defederalization of airports were adopted, the application of these data show that a reasonable ticket tax applied to domestic commercial airline passengers should be at the 3 percent level.

THE NEED FOR EFFECTIVE CAPITAL RECOVERY AND INVESTMENT INCENTIVE LEGISLATION

Significantly improved airline industry earnings are dependent upon a healthy and growing national economy, restored consumer confidence, increased employment and productivity, and lower inflation rates. Immediate, positive tax policy changes are imperative in attaining these goals. The airlines believe there is an urgent need for early enactment of effective capital recovery and investment incentive legislation, both to enhance airline investment capability and to stimulate the national economy.

The Administration's proposed Accelerated Capital Recovery System (ACRS) represents such a positive tax policy change and the airline industry endorses it. The ACRS will do much to help solve the serious capital recovery problems facing American businesses. However, it will do little to meet the current needs of those business enterprises which are marginally profitable, intermittently operate at a loss, or are newly developing companies. Nor does it meet the needs of industries, like the airline industry, that experience wide cyclical variations in profitability and have very heavy demands for capital investment. An improvement in the investment tax credit program is urgently needed to deal with the problems of these companies and industries.

The investment tax credit program was designed to encourage business to invest in new plant and equipment to enhance productivity and employment. The credit is earned by making an investment. Credits earned are used to reduce taxes. Profitable companies have the cash benefit of the credit paid to them immediately through a current reduction of income tax liabilities. On the other hand, unprofitable or marginal companies do not receive immediate benefit of the credit, and may never receive it under existing law. Such companies need the benefit of the credit to reduce the cost of acquiring capital equipment. Thus, the current investment tax credit program should be modified in order to make it more effective. For example, the airlines stand to lose a substantial amount of earned credits as a result of the current earnings outlook of the industry. The airlines need the ability to use both prior earned credits and new credits as well.

The airline industry of the United States faces an $87 billion investment need in the 1980's. An investment of this magnitude is essential to maintain an efficient and reliable national air transportation system. Such an investment is entirely consistent with several important national policy objectives, including energy efficient improvements, greater productivity, meeting environmental concerns, and creating employment. However, the required airlines' investment will not be possible in the absence of significant improvements in the national economy, airline earnings, and investment incentive opportunities.

The airlines believe that effective capital recovery and investment incentive legislation is needed and the proposed ACRS represents a substantial step in the right direction. However, a more complete and effective capital recovery system should incorporate investment tax credit improvements, including a provision providing for the refund of earned but unused investment tax credits.

FEDERAL BORDER-CROSSING REQUIREMENTS IMPOSED ON INTERNATIONAL AIR COMMERCE

The responsibilities of the U.S. Customs Service and the U.S. Immigration Service have been established by the Congress. The resulting inspection requirements imposed on air commerce at our international airports apparently are considered necessary in the broad national interest. They do not uniquely benefit airlines or airline customers. So long as the national interest continues to require such inspection requirements, there must be a concomitant obligation to provide the necessary means for their efficient accomplishment.

Customs and Immigration inspector staffing has not kept pace with the growth of air transportation and continues to be seriously inadequate at airports where international air travelers and freight enter the United States. There are severe bottlenecks during the inspection process, and lengthy delays have been experienced at such airports as Atlanta, Chicago, Honolulu, Houston, Los Angeles, Miami, Montreal, New York, and San Francisco. These already intolerable problems will worsen as air traffic continues to grow, unless steps are taken promptly to assure adequate inspector staffing resources and to simplify existing inspection requirements and procedures.

Current federal employment resource planning and authorization proposals are not encouraging in this connection. We are informed that at least 35 of today's Immigration airport inspectors will be cut immediately, and that the number of Immigration inspectors at airports will be further reduced on October. Similarly, we understand that at least 80 Customs airport inspectors will be cut in October. Added to the disruption and delay caused by the present shortage of airport inspectors, these reductions will result in airport inspection chaos and may well force air service interruptions. Congressional action is needed to prevent these unfortunate consequences and to assure that the federal government's responsibility for carrying out applicable Customs and Immigration laws is efficiently fulfilled.

While significant airport inspector workload reductions may not be possible in the absence of major changes in the underlying Customs and Immigration statutes, opportunities exist for inspection simplification and modernization by administrative action. Examples of such opportunities are set forth in the attachment to this statement. If these and other changes to reduce and simplify the inspection process are not forthcoming, action must be taken to permit the federal government, through increased staffing authorizations, to carry out its statutory responsibilities efficiently.

The airlines fully agree that determined efforts are necessary to reduce the growth of federal spending in order to spur economic recovery and expansion. We do not seek special treatment. We consider an effort to assure the availability of resources adequate to administer efficiently laws enacted for the public good to be consistent with that essential national economic objective. Our primary interest is in seeking to assure that Customs and Immigration responsibilities, and the means by which they are carried out, do not nullify or erode the benefits of air transportation—benefits which are wholly dependent upon the speed, efficiency, and reliability of airline service, and are in closer harmony with the needs of millions of air travelers and air shippers.

The Air Transport Association and its member airlines appreciate the opportunity to provide our views regarding tax policy and expenditure reductions for the United States. We will be pleased to provide this Committee with any additional information that may be desired.

Attachment.

INSPECTION SIMPLIFICATION AND MODERNIZATION OPPORTUNITIES

1. Extension of preclearance—inspection of passengers and baggage prior to departure from a foreign country—to more locations abroad.

2. Introduction of a machine readable United States passport system at airport-of-entry.

3. Extension of the one-stop inspection procedure now operational at Edmonton, Houston, Los Angeles, Philadelphia, to other United States airports-of-entry and preclearance airports.

4. Reallocation of headquarters and regional Customs and Immigration resources to increase inspection agency manpower complements in the field.

5. Implementation of the red/green door inspection procedure—or a modification of it—whereby the traveler determines whether or not he must go through Customs formalities.

6. Adoption of a procedure whereby the passenger is inspected by Customs before waiting to claim his checked baggage.

7. Consolidation of arrival and departure information required by Immigraton and Customs.

8. Consolidation of the several inspection procedures required for the entry of travelers into this country.

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STATEMENT TO THE
SENATE BUDGET COMMITTEE
AND THE
HOUSE BUDGET COMMITTEE
ON
THE REVISED FISCAL YEAR 1982 BUDGET
BY
LEAGUE OF WOMEN VOTERS OF THE UNITED STATES
MARCH 13, 1981

The League of Women Voters of the United States is a citizen education and political action organization composed of over 1350 Leagues in the 50 states, the District of Columbia, the Virgin Islands and Puerto Rico. Members of the League of Women Voters are gravely concerned about inflation and unemployment, as concerned as is every member of the Senate and House Budget Committees. Largely because of these economic problems, the prevailing mood of the country is one of rapidly waning confidence in government and its ability to solve problems. It is our belief, however, that the particular proposals of the Reagan Administration to reshape the budget will neither make America stronger nor restore public confidence in Washington.

The proposals do not set forth a period of belt-tightening shared by all, after which America can again grow and prosper at all levels of our society. Instead,

many vital social service programs are marked for extinction and others will be hopelessly emasculated. These unwise and drastic cuts in the budget will have disproportionately severe impacts on the poor and disadvantaged of this country. America's impoverished minorities, women, seniors and disabled will be among those drastically hurt.

Similarly, many of the announced budget cuts will adversely affect the poorest of the poor in the nation's cities. Cities and towns in the industrialized heartland -- the most distressed areas -- will bear the heaviest burden in these so-called "across-the-board" budget cuts.

In addition, the Administration recommends misplaced cuts which will undermine the progress this nation has begun to make in protecting the environment and promoting energy independence. We say misplaced, because there are some cuts we believe the Administration should have made but did not, e.g. reductions in spending for synthetic fuel subsidies and new highway construction. Conversely, the League strongly opposes cutbacks in funding for conservation and solar energy programs; such cuts belie the fact that the nation's dependence on foreign oil is a major cause of today's inflation.

Looking beyond the domestic cuts, cuts made in the foreign assistance budget are equally myopic. The proposed reduction in US support for multilateral development institutions will undoubtedly hold back development in Third World countries, our largest and fastest growing export market. We also oppose the Administration's emphasis on short-term military assistance at the expense of long-term economic aid to the least developed countries.

Because the League of Women Voters is a diverse organization, we have looked at a large number of the proposed budget reductions. Our comments will fall into roughly four basic areas: human needs, urban needs, natural resources and energy, and international economic development assistance. And, for those who would criticize us and others as bleeding hearts who offer rhetoric and no solutions, we will indeed offer ways in which we believe the federal budget can be cut.

While this statement reflects the national position of the League, attached is a sample of the budget analysis being made by local Leagues across the country. This particular one, which appeared in the Congressional Record on February 24, was sent by the League of Women Voters of Chicago, Illinois.

HUMAN NEEDS

Drastic budget cuts are being proposed for programs that are the backbone of support for poor families. In addition to slashing funds for such programs as food stamps, AFDC, and CETA, the Reagan Administration is also considering consolidating about 40 social services programs into a single block grant. Such action would double, and in some cases triple, the hardships poor families are facing because many of them depend on a combination of income maintenance and social welfare programs. The League is vigorously opposed to cuts in such programs, and opposes the proposed social community services and health program consolidation. We believe that funding and services targeted to the poor and disadvantaged must continue to be mandated at least at their current level of funding and directed to those who need it most. Furthermore, funding of essential social welfare services should not be left to the discretion of the states who have either had insufficient will or resources to provide the services.

Food Stamps

The Administration has proposed cutting close to $2 billion from the food stamp program for Fiscal Year 1982. Four major changes to accomplish these cuts are called for: (1) deducting the value of school lunches from a family's food stamp allotment where children have access to a free school lunch program; (2) implementing a 90 day retrospective accounting procedure, whereby a family's eligibility for food stamps would be based on its average family income over a three month period before it applies for food stamps; (3) a reduction in gross income eligibility levels; and (4) a change in the cost-of-living adjustment so that benefits lag 4 to 15 months behind the actual cost of the Thrifty Food Plan.

The nation's 22 million poor people who depend on food stamps would face drastic reductions in their monthly coupon allotments as a result of these cuts. Children make up 53% of all food stamp recipients, and the elderly constitute 8%. For these people, the food stamp program constitutes a nutrition program as well as an income maintenance program.

Proposals addressing school lunch and the 90-day retrospective accounting proposal are the most regressive. Because food stamp benefits average only 44¢ per person per meal, they can be viewed only as a supplement not as three nutritionally adequate meals a day. Therefore, the free school lunch should not be viewed as duplicative. Thus, we are opposed to having its cost deducted from a family's monthly food stamp allotment. The 90-day retrospective accounting proposal would not only create a bureaucratic nightmare, but would also deny families food stamps when they need them the most, and allow them to keep receiving benefits when they no longer need them. We must recognize that families who

hover on the edge of poverty have no money to put away for food three months in case they are suddenly struck by unemployment.

AFDC

Food stamp outs are only a part of the total package of cuts that will devastate poor families. These families will suffer doubly because of proposed cuts in the Aid to Families with Dependent Children (AFDC) Program of more than $520 million. However, this could mean a "real" AFDC benefit reduction of as much as $900 million in cuts with the additional loss of the state matching funds since the federal government only pays about 52% of the national cost of AFDC benefits.

These proposals cannot achieve any savings without real benefit reductions. Reductions would be particularly concentrated on poor working families who are receiving AFDC to supplement meager earnings; and, reductions mean that children would bear the brunt of the proposed cuts.

A particularly disastrous effect of the proposals to cut money from AFDC is the recommendation to reduce the earned income that could be deducted or "disregarded" in determining a family's eligibility. Such a change would create serious disincentives to work and would make it more difficult for recipients, particularly single mothers, to ever get off welfare.

Retrospective accounting, another one of the tools proposed to accomplish budget savings, could mean that a family would have to wait two months for a grant increase to meet changes in circumstances such as the loss of a job. In addition, the Congressional Budget Office acknowledges that part of the "savings" will

result from non-payment of aid to families legitimately entitled to assistance who are unable to complete the more complicated forms required under this system.*

The League urges you to adequately fund the AFDC program and maintain it in its present form.

CETA

The President's proposal to eliminate the Public Service Employment (PSE) component of the Comprehensive Employment and Training Act (CETA) at the end of fiscal year 1981 means the elimination of job and training opportunities for over 340,000 persons. Virtually all of those who will be affected by the cuts are economically disadvantaged. Budget savings through cuts in CETA would be illusory. Those affected by the cuts and, indeed, by the freeze on PSE hiring already in effect, could be forced to turn to public assistance or unemployment compensation. The Congressional Budget Office has estimated that between 15% and 25% of the "savings" from cutting PSE would show up as costs in the income transfer parts of the budget, so that a $1 billion cut in PSE would result in an immediate $250 million increase in federal public assistance accounts. Long-term joblessness would compound this amount.

Studies show that CETA PSE is the cheapest form of job creation. While the net cost to the government of a PSE job slot in 1980 was approximately $7300, it is estimated that the same slot would cost between $30,000 and $40,000 in tax incentives to private industry to encourage them to provide the same job opportunity.

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* CBO study Reducing the Federal Budget: Strategies & Examples, Fiscal Years 1982-1986, p. 176.

Moreover, CETA PSE has been successful in moving the structurally unemployed into jobs in the private sector. Recent data from the Department of Labor indicates that after one year, 64% of PSE participants were employed in the private sector.

In addition to the elimination of PSE, further cuts are planned in CETA which would reduce the number of job training slots available to unemployed youth. These cuts would be achieved by merging two programs--the Youth Employment Training Program and the Youth Community Conservation Improvement Program--with existing labor training programs for adults, and by reducing the combined funding by almost 20%. This comes at a time when unemployed youth, particularly minority youth, face the highest unemployment rates in the nation.

It is inconceivable that effective job training programs which have provided training and employment opportunities for millions of jobless people will be virtually eliminated, particularly when this will make more people dependent on income maintenance programs for survival. The League is opposed to the disproportionate share of the budget cuts that CETA must bear.

Child Nutrition

The Administration has proposed deep cuts in child nutrition programs, while at the same time maintaining that the free school lunch program will remain untouched. However, the cuts proposed for the entire school lunch program are so substantial that a number of schools would be forced to drop out of the program completely. In the process, poor children would lose access to a free school lunch, thus abrogating the President's claim that the free school lunch program will remain

as part of the "safety net" for poor people. In addition, the proposed increases in costs to children of the near-poor working families would make school lunches prohibitively expensive for many families.

Cuts in the child care food program would also eliminate support for nearly one-half of the food provided to very young children in day care centers.

Despite Administration assurances that Head Start will not be affected by the budget cuts, Head Start centers in fact rely on this assistance, and any cuts in the nutrition program will severely impact on their fragile budgets as well.

The League opposes the depth of the budget cuts in child nutrition programs--cuts which literally take food out of the mouths of poor children.

Supplemental Food Program for Women, Infants and Children (WIC)

Budget cuts have also been proposed in the WIC program. This program provides nutritional supplements for pregnant and nursing women and very young children--all of whom are poor. The proposed levels for fiscal year 1982 would cut $300 million from the program; this represents a 30% decrease from 1981 levels and would eliminate 700,000 women and children from the program.

The WIC program is an integral part of the effort to improve this nation's infant death rate (15th among industrialized nations) and to decrease birth defects and infant health problems. The federal government spends billions of dollars for institutional care, special education and other services for individuals who

suffer from the effects of inadequate nutrition before or just after birth. The preventive effects of the WIC program are well worth the cost -- both in dollars and in human terms.

Social/Community Services and Health Program Consolidation

As mentioned earlier, the League opposes the massive consolidation of a large number of domestic, social and health programs, including such programs as Title XX, the Community Services Administration (CSA), low income energy assistance, and possibly Legal Services, into one block grant to the states. Along with consolidation, the Administration proposed a 20% cut in the total amount of money available for such programs. Such a cut would amount to a 30-50 percent reduction in real support for such programs, considering the impact of inflation and the likelihood that a substantial amount of the funds would be required for administration at the state level.

Consolidation would mean severe cutbacks and reduced effectiveness in all of these programs. The League is particularly concerned about reductions in two of these programs. Cuts in day care, largely funded through Title XX, would create a disincentive for single mothers to work, and would result in pushing more women into a permanent underclass of poverty and public assistance. And, reduction of funds for the low income energy assistance program would adversely affect the poor who cannot absorb rising energy costs without seriously depleting their resources for the other necessities of life.

Legal Services

The League is also concerned about the rumors concerning continued funding for the Legal Services Corporation. Inclusion of legal services in the social/community services block grant would strip the Corporation of its independent status and would mean that legal services to the poor would no longer be guaranteed. Even more distressing is the rumor that the budget contains no funds for legal services whatsoever.

The mission of legal services is to ensure equal justice under the law for the poor. Under the Constitution, due process of law is guaranteed to all. To eliminate or drastically cut back on the provision of legal services to the poor constitutes a denial of a constitutionally guaranteed right to a significant segment of our population.

Housing

The National Low Income Housing Coalition estimates that some 500,000 low income families are confronted by a serious housing shortage each year. The League has been long committed to the dual objectives of providing fair housing and expanding the housing supply for low income families. We have continuously urged that at least 400,000 additional units of low income housing be provided each year to help meet the critical housing demand. It is important to note that the provision of 400,000 units would only begin to address the need. Therefore, the Reagan proposal of 175,000 units of Section 8/public housing would be grossly inadequate to meet the needs of low income families.

The budget proposal would also eliminate two key housing programs: the Section 235 Low Income Homeowners Program, which has enabled many low income families to purchase their own homes, and the Section 312 Rehabilitation Loan Fund, which has enabled many low income families to make major improvements in their homes. We believe both of these programs are essential and should be funded at their present level because they provide low income families with the opportunity to secure decent and liveable housing.

The Administration also proposes to save $9 million in FY '81 and $232 million in FY '82 by increasing the maximum allowable rent contributions paid by tenants of federally subsidized housing from 25% to 30% of their income. The League has consistently opposed such a change because of the onerous burden it would place on low income people, whose budgets are based entirely on necessities and thus have little or no flexibility.

Education

The Administration proposes not only to cut federal aid to elementary and secondary schools by at least 25 percent, resulting in budget savings of $3.6 billion, but also to consolidate 45 of the 57 existing programs into two block grants, one to be administered by state educational agencies and the other by local educational agencies. The LWVUS is opposed both to the crippling cuts proposed and to the breadth of the consolidation.

Of greatest concern to the League are the cuts and consolidation for two major programs aimed at providing assistance for the disadvantaged: Title I

of the Elementary and Secondary Education Act and Education for All Handicapped Children (PL 94-142). Another key program that would be folded into the consolidation is Emergency School Aid Assistance Title VI,(ESEA), which provides assistance to desegregating school districts.

The League has a long held position in support of equal access to education, and has consistently advocated the need for the federal government to support equal educational opportunities for disadvantaged children. We are concerned that under the reduced funding level proposed, school districts would not adequately serve target populations. We know, for example, that even under existing levels of Title I funding, only 67 percent of the eligible children are reached. But even if school districts choose to fund compensatory and special education programs, there is no guarantee that resources would go to the poorest schools or neediest children.

The consolidation plan would eliminate safeguards that enforce civil rights, assure that funds are targeted to the neediest children, and weaken provisions promoting parent and community involvement in educational decision making.

The state consolidation plan includes many programs that provide direct educational services to handicapped, neglected and delinquent children, as well as support services. It also includes two programs of special concern to the League: Title IV of the Civil Rights Act of 1964 and the Women's Educational Equity Act. Title IV provides essential technical assistance on race and sex desegregation to school districts; WEEA funds the development of model programs to promote sex equity. It particularly makes no sense to include WEEA in a block grant

to states, since its primary purpose is to develop programs that can be replicated and disseminated for use around the country.

Under a system in which local educational agencies are free from all legislative and regulatory prescriptions, they will tend to spend funds on politically popular programs rather than on special aid for poor, handicapped and other disadvantaged children. It is important to note that the statutory and regulatory requirements of existing federal education laws were formulated in direct response to a national mandate to overcome the history of inadequate attention on the part of state and local education agencies to the special needs of the educationally disadvantaged.

Surveying the education picture, we also want to reiterate our firm opposition to tuition tax credits for the parents of children attending private elementary and secondary schools. It is estimated that adoption of tuition tax credits, as advocated by the Administration, would cost approximately $4.7 billion. We find it unconscionable that the Administration advocates tuition tax credits, which would primarily benefit upper income families, at the same time that it proposes making false economies at the expense of our neediest school children.

URBAN NEEDS

The proposed budget cuts in federal programs designed to aid the poor and the cities imply an urban policy of increasing the burdens on city budgets without providing resources to meet them -- a policy of sheer neglect. The fate of America's older urban areas, particularly those in the Northeast and Midwest, is especially threatened by such cuts. The cities and towns in the nation's

industrial heartland will bear the heaviest burden in these so-called "across-the-board" budget cuts. This is because the categorical programs and, in some cases, block grant programs that are going to be cut back are primarily programs that serve distressed areas. These are the "people" programs that serve those in need and the community programs that serve neighborhoods (see Human Needs section above) as well as those urban programs initiated in the last few years to target aid to economically distressed urban areas.

Economic Development Administration

The League is distressed to see that funding for all Economic Development Administration (EDA) programs would be eliminated in the FY '82 budget. The EDA, through a variety of loans, grants and other assistance, provides incentives for community investments and helps create permanent private sector employment in distressed areas. It is estimated that current EDA investments will create or preserve more than 216,800 jobs and approximately $2.5 billion in private investment. In the last few years, EDA concentrated on promoting small and medium sized business -- the very type of businesses which have provided over two-thirds of all new net jobs in this country. The League was one of the groups which sought to strengthen this program in the last Congress. The open market place cannot and will not serve to substitute for the functions EDA provides.

UDAG/CDBG Merger

Another highly questionable proposal is the meshing of the Urban Development Action Grant (UDAG) program into the Community Development and Block Grant (CDBG) program. Even if all of UDAG's program monies were to be added to the pot of

the CDBG funds, it would not be possible to guarantee that UDAG's purposes would be served. CDBG is basically a "no strings" block grant approach, while the UDAG program was created specifically to address the economic and infrastructure deterioration problems of severely distressed cities and urban counties. By encouraging the private sector to invest in economically distressed communities, UDAG has leveraged a commitment of almost six dollars in private funds for every one dollar in federal funds, resulting in the creation of 178,000 permanent jobs in the hardest hit areas alone.

As in the case of the EDA, it is not reasonable to expect that market forces, devoid of special incentives that UDAG supplies, can provide the funds for investments in the most distressed areas. Members of Congress need only go as far as Baltimore, to the Harbor Place Market, to see an excellent example of what UDAG can do. CDBG provides needed community services, but it does not guarantee the targeted assistance provided by UDAG.

Urban Mass Transit

The cuts in urban mass transit programs have been called "draconian" -- not too much of an exaggeration. They indicate an abrogation of federal responsibility in public mass transit. The Administration would greatly curtail or indefinitely postpone any federal financing for new mass transit rail systems and would totally phase out operating subsidies by 1986. These proposals fly in the face of the clear national interest in reducing dependence on foreign oil and reducing air pollution caused by private automobiles. The idea that state and local government or the farebox can absorb all financing responsibilities for mass

transit is a misconception. The cities most in need of help to construct and operate reliable public transit systems are most often those cities which, for a variety of reasons, are distressed.

The fare-hikes necessitated by these cuts will most likely have two results: 1) fares will be beyond the means of the most transit-dependent Americans -- the poor, aged, young and handicapped -- necessitating subsidies from the cities; and 2) many of the more affluent, middle class riders will be lured back into the private auto. A New York Regional Plan Association study indicates that higher fares would reduce ridership by as much as 11 percent, exacerbating energy conservation and air pollution problems.

Energy Assistance

Another area of federal responsibility and control that will be shunted off to state and local governments is that of the burdens of energy problems caused by escalating fuel prices and shortages. Emergency assistance monies for energy emergencies and fuel assistance for low income persons will be abolished. These cuts, like the cuts in mass transit, are in direct contravention of Congressional intent in the passage of the Windfall Profits Tax to accompany decontrol of oil prices.

NATURAL RESOURCES AND ENERGY

Energy

We believe national energy policy should effect a fundamental change in the nation's use of energy to reflect the inescapable fact of diminishing resources and rising prices. Therefore, using energy more efficiently should be the central

feature of U.S. energy strategy. Such a strategy must address the short-term problem of dependence on imported oil and consequent vulnerability to potential supply disruption, as well as the long-term problem of stretching out our finite resources until we can tap into safe alternative sources. The proposed Administration energy budget favors expensive and environmentally destructive supply projects -- requiring long lead times -- over more benign solar and conservation programs which offer the greatest potential short-term energy supplies. The proposal will lead the country in the wrong direction.

Synthetic Fuels

Synthetic fuel commercialization programs should be totally cut. The Department of Energy's fossil energy R & D program should not shoulder the financial burden and risk for commercialization projects which are more and more attractive to industry and more economically viable as decontrol of oil and new gas prices proceeds. Large federal commercialization projects serve to subsidize expensive, inefficient and perhaps environmentally dangerous technologies. Rather, the program should be restricted to legitimate research and development targeted on monitoring and evaluating existing technologies and study of the feasibility of new technologies.

For this reason, we were heartened and were prepared to support the original budget proposals from Mr. Stockman's OMB. But the Administration seems to have backtracked. While four of the original five DOE supported "demonstration" plants would be rescinded, only $300 million would be cut from the alternative fuels program and $5 billion which was to be rescinded will be transferred to the

U.S. Synthetic Fuels Corporation, an off-budget entity. Also the Administration has apparently reversed its earlier decision to limit the Synthetic Fuels Corporation to supporting $12 billion in smaller-scale demonstration projects, and seemingly will instead allow the Corporation to push ahead with up to $20 billion in full-scale projects.

We believe the Synthetic Fuels Corporation program suffers the same infirmities, on even a larger scale, as the DOE fossil energy R & D program which funds commercialization projects. There are no real institutional barriers to the use of these fuels.

Therefore we urge the Congress to go ahead with the cuts in synthetic fuels programs originally proposed by OMB.

Solar and Conservation

We are dismayed at the drastic cuts in both the solar and conservation budgets. We oppose the Administration plan to slash over 77% from conservation and more than 62% from solar. The Solar and Conservation Bank should not be strangled just eight months after its birth.

The Administration cuts are proposed on the assumption that higher energy costs and tax incentives alone will take care of energy conservation and encourage the use of solar. Of course, higher prices will have, indeed already have had, a significant effect; and for that reason we supported gradual decontrol of the price of oil and new natural gas. But higher prices will not provide capital to the vast number of individuals and businesses who can use conservation and

solar. Higher prices and tax incentives will not enable tenants to control the design and operation of the residences and office buildings they occupy and whose energy operating costs they pay. Higher prices will not ensure that we achieve the maximum cost effective improvements in efficiency, even though such improvements are clearly in the national interest.

In sum, we believe that federally funded conservation and solar programs are needed to expedite "market forces." They provide the diversity of approaches needed to help break down institutional barriers to use of these resources. The Bank, for instance, was designed specifically to assist those who would not be expected to benefit from tax credits. These programs can assist citizens in the large number of small applications of solar and conservation technologies.

Ignoring all recent major energy studies and without new analysis, the Administration axes the Solar and Conservation Bank, building and appliance standards, utility audit programs, funds for state energy offices, and public outreach programs. Crippling reductions for local school and hospital conservation programs are proposed. We submit that this is the wrong way to go.

Environmental Protection Agency

The municipal sewage treatment construction grants program is an important element of the drive to clean up the nation's waters. It should not be zero-funded or transformed into a block grant program. Zero funding would kill program momentum and would not serve to protect the federal investment. States which operate the program cannot plan on the basis of abrupt funding shifts.

Transforming the program into block grants would terminate important cost controls and would likely focus the program away from improving water quality.

Budget cuts can be made, however, without sacrificing clean water goals if accompanied by reform of the program. Better targeting of the program, more use of innovative and alternative technologies, less orientation toward new development, increased use of industrial and residential user charges, emphasis on decentralized systems in non-urban areas, separate treatment of waste by industry, better water conservation efforts, more effective training and technical assistance for operation of plants -- all would make for a more cost-effective program.

Many other EPA programs are vital to protecting the nation's health and welfare. For example, programs under the Clean Water Act, the Clean Air Act, Superfund, the Resource Conservation and Recovery Act, the Toxic Substances Control Act, and the Safe Drinking Water Act are designed to protect against toxic substances. The public continues to strongly support environmental programs, as indicated by public opinion polls. These programs should not be gutted, either directly or by turning responsibility over to states which don't have financial or technical capacity to carry them out.

The new Superfund program must be maintained at the initial 1982 budget level. EPA must have sufficient personnel to fulfill its responsibilities to the American people. EPA's public participation programs, mandated by law, are, in our opinion, a proven method of ensuring cost effective programs by enabling citizens to bring their knowledge and concerns into the development and implementation of programs.

Council on Environmental Quality

The President's Council on Environmental Quality has proven its ability to call attention to emerging environmental problems and to mediate conflicts among federal agencies. Cutting this office would yield small savings and would be short-sighted. Without this independent mediator, agencies involved in the issues would have to mediate their own disputes, a situation not likely to achieve results.

Coastal Zone Management

The Administration proposes to totally eliminate funding to 25 states and territories which are in the early stages of implementing federally-approved Coastal Zone Management (CZM) programs. Abrupt termination of these state grants is unwise and irresponsible. Just last fall, Congress reaffirmed the nation's commitment to the wise use and management of the coast by reauthorizing the CZM program for five years. States are now looking to the federal government for direction in considering new and specific national interest goals, such as energy production.

This program has made progress toward achieving many of its objectives: better coordination between federal, state and local governments; planned rather than haphazard economic development of much of the coastal zone; and greater predictability for both public and private investments in industry, housing, recreation and conservation. The budget proposal assumes that states have the capability of fully financing their own CZM programs but most states have already indicated this is an unlikely prospect. Premature termination of CZM funding is bad business for the national interest and unfair to the states. We support full funding for FY '82.

INTERNATIONAL ECONOMIC DEVELOPMENT ASSISTANCE

Looking beyond the afore-mentioned cuts in the domestic budget, the League vehemently opposes the proposed 26 percent reduction in the fiscal 1982 budget request for foreign economic development assistance. The severity of these cuts will reduce further an intolerably low level of US contribution to development assistance. In addition, such cuts strike hardest at US contributions to multi-lateral assistance programs, cut by 38 percent to the lowest level in American history.

In this year of extreme budget restraint, the League of Women Voters is concerned that many important programs designed to benefit the poorest of the world's poor will face devastating cutbacks in funding levels. Despite the miniscule allocation of US dollars for foreign aid -- about 0.20% of the GNP, less than one percent of the federal budget -- Congress has cut the Administration's request every year. These cuts in spending indicate to the rest of the world, and the developing nations in particular, a lack of US commitment to development. Thus, at the very outset of the budget process, drastic cuts made in the level of US contributions to international organizations and the multilateral development banks reflect a serious weakening of the leadership necessary to keep the system of international cooperation running smoothly and effectively.

Most importantly, League members firmly reject the rationale which clearly under-lies these proposed budget cuts, i.e. that bilateral aid programs tied to narrow American security interests should receive a higher priority than aid directed through multilateral channels. Such a myopic policy will undoubtedly hold back

development in the Third World, our largest and fastest-growing export market. Furthermore, we oppose the Administration's predilection toward short-term military and security supporting assistance at the expense of long-term development aid to the least developed of Third World countries. We believe that US policies which help developing world reach self-sustaining economic growth are an essential requirement for world peace.

The LWV supports US development efforts aimed at addressing the needs of the poorest countries, as mandated by Congress in 1973 and adopted by the Agency for International Development (AID) in its New Directions "people oriented" programs. As a result, the proportion of US development assistance going to the poorest countries has increased, even though total US development aid has continued to decline to its lowest level in history. The League is concerned, therefore, that the new Administration's budget cuts will severely undermine the achievement of this New Directions mandate for development assistance. We are frankly appalled at the Administration's callous acknowledgement that cuts in US aid to multilateral organizations will "mainly affect the poorer countries of Africa and the Asian subcontinent." Similarly, we take offense at the recommendation to concentrate bilateral aid on countries of key importance to the US, perhaps to the detriment of "lower priority recipients" in "countries of lesser importance." **

** From p. 3 of the OMB's "Foreign Aid Retrenchment" memorandum. January 27, 1981.

Multilateral Aid

Because the League advocates that the proportion of US assistance given through multilateral institutions should be substantially increased, we are particularly troubled by the proposed reductions in funding levels for:

--the United Nations Development Program, cut by $15 million or 10%. UNDP is the world's largest supplier of technical assistance grants and the focal point of UN development efforts. Its achievements continue to be exceptional; since 1959, UNDP surveys and feasibility studies have yielded over $34 billion in development investments.

--the Voluntary Fund for the UN Decade for Women, cut by 50%, from $1 million to $.5 million. The Voluntary Fund was created by the UN General Assembly following the International Women's Year, 1975. The Fund supports innovative and often experimental projects aimed at promoting the participation and integration of women in the development process. However, pledges to the Fund have not kept pace with demands, and notwithstanding the UN General Assembly's pledge of support for a continuation of the Fund's activities beyond the Decade for Women (1976-1985), the question now is whether the work of the Fund can continue even through 1985.

--the International Fund for Agricultural Development, cut almost 50% from $85 million to $45 million. IFAD is a specialized agency of the UN charged with raising food production in the poorest countries. As important as its mission, is the innovative financing that shapes the organization's budget: a split among industrialized, developing and OPEC contributions.

--the International Development Association, full funding requested but payments for fiscal 1981, which have not been appropriated, reduced from $1.08 billion to $540 million. This month, IDA, soft-loan window to the World Bank, runs out of money to provide new loans. The Administration's proposal to defer US funding obligations for this vital development bank signals to the 32 other IDA replenishment nations that the US cannot be held accountable to an internationally negotiated pledge.

Bilateral Aid

The League of Women Voters also opposes the recommended 16% across-the-board cut in funding for the bilateral aid programs administered by the Agency for International Development (AID). This reduction of approximately $500 million from the FY 1982 Carter budget request for AID programs relegates bilateral aid to roughly the same inadequate levels as under the continuing appropriations resolution for fiscal years 1980 and 1981. But even more significantly, it is accompanied by disproportionate funding increases for military assistance (up $150 million) and the Economic Support Fund, ESF, (up $750 million). Although the ESF meets a variety of needs and does support many development programs which directly benefit the poor, it was established to promote economic and political stability and, thus, the bulk of its resources now go directly to Egypt and Israel.

In conclusion, the League of Women Voters strongly urges members of the Budget Committees to oppose the Reagan Administration's budget revisions for fiscal 1982 bilateral and multilateral economic development assistance. These harsh budget cuts will undermine US relations with the developing world and run counter to

the tangible benefits of development assistance to our economy. Moreover, such cuts take money away from vital social and economic programs which have already made significant progress toward mitigating world poverty and suffering.

BUDGET SAVINGS AND REVENUE MEASURES:

Energy/Synthetic Fuels

The LWV believes that a substantial budget savings could be attained by ending federal subsidies for synthetic fuel programs. The League supports cutting off DOE's synthetic fuels commercialization program for a $275 million savings in FY '81 and a $864 million savings in FY '82. See NATURAL RESOURCES AND ENERGY section above.

Highways

We believe that federal funding for highway construction should be substantially reduced. The interstate highway system is ~~now 94%~~ complete and the estimated cost of fully completing the system is about $76 billion. We believe the interstate highway system should be considered complete and no construction funding provided for 1982.

Similarily large cuts in the budget for construction of primary and secondary highway systems should be made. Not only does new highway construction often lead to unwise land use patterns, but in this age of budget austerity such funding is not as important as that for social programs.

Water Projects

The Carter 1982 budget for construction, operation and maintenance of Corps of Engineer water projects is $3.08 billion, of which about $1.9 billion is for

general construction. Four projects, Lock and Dam 26, the Red River Waterway, the Richard B. Russell Dam, and the Tennessee-Tombigbee Waterway, account for $493 million of this construction. These four projects are economically unsound and environmentally destructive. They should not be funded in 1982 and should be phased out as soon as possible. In addition, we recommend that major cuts be made in the remainder of the general construction budget of the Corps to weed out economically unsound and environmentally destructive projects.

The budget for the Water and Power Resources Service in the Department of Interior (formally the Bureau of Reclamation) provides other opportunities for large savings. Four projects account for $297.8 million of the proposed 1982 construction budget of $652.6 million. The Central Arizona Project, the Bonneville Unit of the Central Utah Project, the North Loup Division (Nebraska) and the O'Neill Unit (Nebraska) are of doubtful economic value. So, too, is the Garrison Diversion Project. A major cut in the WPRS budget is advisable.

We believe the Reagan Administration misses significant needed budget savings and opportunities to cut waste by only proposing a very small reduction in water projects construction. The inequity of the Reagan budget is shown by these small cuts compared to major cuts in social programs.

User Charges

We support the Administration's proposal to increase waterway user charges. Charges should recover operating, maintenance and new construction costs. We applaud the courageous step the Administration takes with this initiative.

We believe user charges should also recover costs for expanding and maintaining deep draft ports and channels; highway user taxes should be reallocated to reflect the damage that heavy trucks inflict on the federal highway system.

Several public lands resource pricing policies should be changed to reflect the fair market value of the resource and, in many cases, to ensure sustained yield. These are: grazing fees, timber prices, coal and outer continental shelf oil and gas leasing, hard rock mining, and federal power and irrigation contracts.

Price and Loan Guarantees For Energy Inefficient and Environmentally Destructive Projects

Federal price and loan guarantees often support industrial and commercial activities which could rely on private markets. The Treasury Department estimates a $52.4 million revenue loss for every $1 billion in federal loan guarantees. More efficient use of natural resources and less environmental destruction would result if the Northwest Power Authority, the Tennessee Valley Authority, the Rural Electrification Administration and the U.S. Synthetic Fuels Corporation authority were trimmed.

CONCLUSION

In conclusion, the League of Women Voters of the United States vehemently opposes the following cuts and consolidations:

HUMAN NEEDS

--$2 billion in the food stamp program

--$520 million in Aid to Families with Dependent Children (AFDC)

--elimination of 340,000 CETA jobs

--reduction of youth jobs and job training slots

--deep cuts in child nutrition programs and the supplemental food program for Women, Infants and Children (WIC)

--consolidation of and 20% cut in social services programs

--consolidation of and 25% cut in education programs

--20% cut in FY '82 budget authority for public housing and Section 8

--elimination of funding for the Legal Services Corporation

URBAN NEEDS

--elimination of Economic Development Administration (EDA)

--merging the Urban Development Action Grant (UDAG) into the Community Development Block Grant (CDBG) program

--postponement of federal financing for new mass transit rail systems and phase out of all federal operating subsidies by 1986

--termination of emergency low income fuel assistance

NATURAL RESOURCES AND ENERGY

--funding for the Environmental Protection Agency (EPA) and the Council on Environmental Quality (CEQ)

--elimination of funding for the Coastal Zone Management (CZM) program

--budget reductions of 77% from conservation programs and 62% from solar programs

--sewage treatment construction grants

INTERNATIONAL ECONOMIC DEVELOPMENT ASSISTANCE

--26% overall cut in US foreign economic development assistance

--38% cut in US voluntary contributions to international organizations

--deferred US payments to several multilateral development banks

--16% across-the-board cut in funding for bilateral aid programs.

However, the League supports budget cuts and changes in the following areas:

--water projects funded by the Corps of Engineers and Water and Power Resources Service

--increases in waterway user charges

--Federal price and loan guarantees for energy inefficient and environmentally destructive projects

--synthetic fuel subsidies, which the Administration originally proposed and then rescinded

--funding for new highway construction

The League believes that the pressures of inflation notwithstanding, only a careful review of budget priorities that takes into account humanitarian, environmental and global variables can ultimately lead to a fair and responsible fiscal policy for this nation.

be required to serve the needs and interests of its local broadcasting area. This would be much better than present FCC attempts to get the Philadelphia and New York stations to provide for better news coverage, attempts that have been well meaning but considerably short of being effective.

The legislation I am introducing today will provide a process for the FCC to follow in order to move a station from a State which has more than enough VHF stations to the two States which do not have any. The bill states that the rights of all broadcasters shall be protected. No license can be removed because of this legislation. However, if the FCC in the normal course of its decisionmaking declines to renew, or revokes, a VHF license, it must move that station from a State that has more than one VHF station to a State that has none if it is technically feasible.

The issue of bringing a VHF commercial broadcasting station to New Jersey and Delaware has broad bipartisan support. During the last session a bill with the same language as the one I am introducing today was reported by the House Committee on Interstate and Foreign Commerce. I hope that the committee will once again find this bill with merit.

On Friday, February 20, Senators WILLIAMS and BRADLEY introduced companion legislation in the Senate. It is my belief that the circumstances surrounding this issue are such that the citizens of New Jersey and Delaware will be successful in their fight during this Congress.●

LEAGUE OF WOMEN VOTERS LETTER TO PRESIDENT REAGAN

HON. HAROLD WASHINGTON

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 24, 1981

● Mr. WASHINGTON. Mr. Speaker, the Chicago League of Women Voters recently sent President Reagan a very timely, thoroughly researched, and factually precise memo on the consequences of his proposed budget reductions for low-income people in Chicago, and across the Nation. The leaders of the league were good enough to share that letter with me. Because they have done such an outstanding job of analyzing the consequences—most of them extremely harmful—of Mr. Reagan's proposed cuts in social programs, I wish to urge all my colleagues to closely study that memo. I would also suggest to my fellow Members of Congress that they encourage other civic groups across the country to undertake similar analysis of Mr. Reagan's proposals. I think they will find, as the Chicago League of Women Voters found, that the budget cuts are a disaster which must be prevented.

The text of the League of Women Voters letter follows:

LEAGUE OF WOMEN VOTERS OF CHICAGO,
Chicago, Ill., February 20, 1981.

President RONALD REAGAN,
The White House,
Washington, D.C.

DEAR PRESIDENT REAGAN: We add the voice of the Chicago League of Women Voters to the nationwide plea by leagues and other concerned citizen groups that your Administration's budget address the basic priority needs of all Americans. In the immediate context failure to do so is inhumane; in the longer prospect the result will be a costly boomerang.

In that vein we applaud the announcement regarding "protected programs," particularly the assurance of continued funding for school lunches and breakfasts, Headstart, and summer youth jobs, all of which are preventive and supportive measures designed to promote the health of both society and individuals.

As for the promise that the proposed budget cuts will not harm the "truly needy," we believe that your Administration misreads both the current programs and the plight of the poor. The broad-gauged legislative vehicles like food stamps and CETA have already been strictly and narrowly targeted to those most in need by restrictive amendments in 1978. The determining income eligibility regulation for most the CETA participation is the poverty line or welfare status. The allowable monthly income for a family of four on food stamps is $642 which is below the poverty line. How much more truly needy must one be?

The harsh fact is that 87% of the cuts you have proposed come from programs for the poor and unemployed.

It is noted with poignant irony that recent reports attest to the success of CETA initiatives: for example, over 5,000 general assistance recipients were moved off welfare rolls in New York City and into CETA training and jobs, providing a vital "middle step" for those who have little chance without preparation. CETA VII provides a further link to unsubsidized work with the provision of tailored training for private sector jobs.

The League strongly urges, also, continued public service employment. Elimination would have a devastating effect on Chicago and Chicagoans—the immediate loss of over 6,000 jobs.

There can be no doubt about the eagerness for work. The opening of seventy Social Security Administration entry level jobs in Baltimore last fall resulted in a line of 10,000 people. Laid-off Wisconsin Steel workers in Chicago have responded similarly to job openings, far too few for their numbers. It is true that eventually despair and bitterness result in the "discouraged worker" who finds himself outside the market system; thus, approximately one million discouraged workers are not counted among the officially defined unemployed.

In Chicago BLS statistics indicate that 800,000 persons are trapped in permanent deprivation with little hope in the mainstream economy of earnings incomes above the poverty line. The Illinois Bureau of Employment Security year-end report said it had over 140,000 applicants and only 11,000 jobs on file, a situation not likely to be reversed soon by tax incentives and reductions. CETA programs, though shrinking and threatened, are an essential retraining and job resource when low-skill jobs are disappearing.

The League is especially concerned about racial inequity. Eighty-five percent of the poor in Chicago are non-white. Unemployment, in fact, exacerbates all inequity; for every 1% increase in unemployment, there is a 2.2% decline in income equality: seniority and hiring practices tend to leave the black male, black female and white female out in the cold. The median wage of black men, age 20 to 55, is 59% of that of whites. The party of Lincoln should view that as an urgent, unfinished agenda.

The idea of shifting social programs to state control is strongly opposed by the League. The result, the League believes, would be fifty welfare systems and inevitable unfairness. The probable net federal cutback implicit in the block grant approach would strain state budgets, particularly those beset by the "Great Lakes recession." The projected food stamp cuts will cost the Illinois economy $80 million—and bring necessary pressure to increase the state's basic welfare grant level. (The Chicago Food Stamp Hotline averages 165 calls per day.) Governor Thompson has already asserted the need to cut Medicaid and has reduced his original increase in school aid, desperately needed by Chicago public schools.

The shrinking supply of affordable housing and the rising cost of mass transit, both of which are severe hardships on the working poor, are thrown into deeper crisis by your budget. Of the highest order of necessity, housing and transit are also prime sources of jobs. Your place in history would be assured, Mr. Reagan, if you would put people to work rebuilding the railroads and housing stock of this nation.

The oft-cited psychological imperative for federal budget cutting is ephemeral when compared with the plight of those affected. Further, contrary to the claims of the Office of Management and Budget, the proposed cuts cannot be equitable; we urge you to note that the cost of necessities—food, housing, energy, health care—rose even faster than the over-all inflation rate, 13.8% compared with 12.3%, a blow with compound impact on the lowest incomes. Removal of aid in any category is a retreat from humane policy. The poor have already sacrificed.

If psychological effect is a purpose in the Administration's proposed budget cutting, the League is more concerned about the signals sent to those who are left out of the economic system. The connection between joblessness and rising crime is now well documented. One percentage point of unemployment increases state prison admissions by four percentage points. With the average total cost of maintaining an individual in prison now approaching $20,000 per year (not to mention the social cost), it is clear that measures that deliberately induce unemployment—or cutting programs designed to train and employ—are myopic and expensive. Jobs programs, now honed to greater effectiveness, offer escape from dependency, a trained work force, and an alternative to crime.

Finally, we respectfully question the matching of problem and solution. By any calculation the proposed budget cuts would have a negligible effect on inflation—a fraction of a percent—too small to justify the removal of aids which are a vital margin on the receiving end. It is at best an unfair gamble, with real suffering as one side of the equation.

Even if the combination of incentive and spending reduction should restore American prosperity, we are worried about what could be the prolonged interim to which you have alluded, the loss of hope for marginal families, and misery-bred explosions.

We hope that meanness will not characterize your Administration, President Reagan. All Americans would be diminished.

Sincerely,

PAULINE PANTSIOS,
President.
BETTY WILLMOTT,
Vice President, Welfare Study.●