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DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2002 BUDGET PRIORITIES

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, MARCH 7, 2001

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FY 2002 BUDGET PRIORITIES

WEDNESDAY, MARCH 7, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10 a.m. in room 210, Cannon House Office Building, Hon. Jim Nussle (chairman of the committee) presiding.

Present: Representatives Nussle, Spratt, Bass, McCarthy, Gutknecht, McDermott, Thornberry, Bentsen, Sununu, Hooley, Kirk, Capuano, Collins, Moore, Fletcher, Honda, and Hastings.

Chairman NUSSLE. I call this meeting of the full committee to order. This is a full committee hearing on the President's budget for Health and Human Services.

Today's witness is the Honorable and recently, within the last half hour, as we understand, sworn in officially by the President of the United States, Secretary of Health and Human Services, former Governor of a neighboring State of mine, Wisconsin. We're honored to have you here today and we look forward to your testimony.

This afternoon we will hear from witnesses involved in economics as well as health care on panels two and three. Then next, we will have a members day hearing, as well as hearings next week on the Department of Agriculture, the Department of State and the Department of Education. We look forward to those hearings as well.

There is no question that, particularly coming from a State such as Iowa, where we have the number one population of older Americans over the age of 85 years old, and I think are ranked number two or three in all other categories involved with seniors, Medicare has become a vital cornerstone program to our entire economic development, not just health care in the service of rural areas. We are very interested in the Medicare program, and let me just highlight one issue in particular that, Mr. Secretary, we have worked very hard on this committee in a bipartisan fashion to achieve.

Over the last couple of years, as I'm sure you note, we have begun running not only surpluses within the Medicare HI trust fund, but we as a Congress have decided to not use that resource, those resources, those surpluses for anything at all except Medicare. In fact, in a bipartisan fashion earlier this year, one of the first bills to pass the House was a Medicare lock box. Again, in a bipartisan demonstration of our support for Medicare, the Medicare surpluses and the need that we set those resources aside for future contingencies, future opportunities such as what all of our constitu-

ents have been talking to us about, and that's a prescription drug benefit, as well as other modernizations.

When you come from a State such as Iowa, as well as Wisconsin, you recognize that in rural areas in particular, there is an abominable reimbursement rate when it comes to paying the bills for Medicare. We all pay the same amount of taxes, but you visit Wisconsin, as I certainly don't have to tell my colleagues from Wisconsin or Iowa or Minnesota, a number of others, Washington, I'll leave somebody out and they'll be discouraged, so I don't want to do that. But all over our country, in the rural areas in particular, we have seen a real disservice from Medicare.

We've tried to do a patchwork quilt in order to achieve some reform. We've succeeded in some areas, we have not quite succeeded in others. We welcome the challenge that has been put on the table by the President and by yourself when it comes to reform.

Mr. Secretary, you are a legend in your own time. You are the person who shed light on the whole issue of welfare. You led this country when it comes to welfare reform. You and your State dragged all of us, in some instances even kicking and screaming, to reform. Speaking as one member, I am delighted that you are going to be serving us in this capacity, to help not only continue the reform in our Nation's services, Government services through welfare, but also in the area of Medicare. We sorely need your guidance, your leadership in this regard as we move forward. So we welcome your testimony here today.

I'd like to now welcome and recognize my friend and colleague, the Ranking Member, John Spratt from South Carolina.

Mr. SPRATT. Mr. Secretary, let me echo what the Chairman has just said and say that your reputation as a constructive reformer, creative reformer, precedes you here in Washington. We're happy to see you in the position you've assumed at HHS, and we're pleased to have you here this morning. Thank you very much.

Chairman NUSSLE. I would ask unanimous consent that all members be allowed to place into the record at this point an opening statement.

[The opening statements follow:]

March 6, 2001.

BUSH BUDGET DIVERTS SOCIAL SECURITY AND MEDICARE SURPLUSES

DEAR DEMOCRATIC COLLEAGUE: I commend to you the attached editorial from the March 5 edition of the Washington Post regarding the budget outline that President Bush submitted to the Congress last week. While the President's outline leaves ambiguous many crucial questions about the budget, the editorial points out that the President's $2 trillion tax cut clearly will undermine Social Security's and Medicare's long-term viability.

The President's budget violates the bipartisan consensus, reaffirmed only a few weeks ago by a near unanimous House vote, that all of the Social Security and Medicare surpluses should be saved to fulfill the existing commitments of those two programs. The President saves only part of the Social Security surplus. And he argues that the Medicare surplus does not exist, while simultaneously putting this supposedly nonexistent Medicare surplus into a reserve to be spent on other things.

Social Security and Medicare surpluses by themselves are insufficient to meet existing benefit commitments. Projected insolvency of these two programs means that they will need resources in addition to the surpluses currently accumulating. The Bush budget's claim that the Social Security and Medicare surpluses can be tapped now to somehow fund privatization and additional benefits for prescription drugs is double counting, pure and simple.

The President's excessive tax cut will force cuts to many priority programs, and it is not surprising that he has declined to specify what those cuts are. However, the most worrisome program cuts the tax cut will trigger are in Social Security and Medicare.

Sincerely,

JOHN M. SPRATT, JR.,
Ranking Democratic Member.

[From the Washington Post, Monday, Mar. 5, 2001]

SPINACH BEFORE DESSERT

The budget outline that President Bush sent Congress last week implies much deeper future spending cuts than administration rhetoric suggested. Some of the deepest—and least discussed—would occur in Social Security and Medicare. The outline accurately describes the perilous long-term financial condition of these programs. That peril could be eased significantly if some of the money the president wants to use for a tax cut were diverted to them instead—if, to use the Clinton phrase, the Bush administration would "save Social Security" and Medicare first.

But it has put the tax cut first. The president and his advisers suggest they have no choice—that they have set aside as much of the budget surplus as they technically can for the next 10 years for the programs for the elderly and still have money left over. They say there's a limit to how far the debt can be sensibly reduced, and that, apart from a tax cut, there's no other way to save the money—keep it from being spent—until it will be needed. But is that explanation the complete truth?

It's likely that they could pay down a lot more debt than they newly claim. And this is not a budget that seeks to rescue Social Security or Medicare. If anything, the administration's proposals would worsen the plight of the programs. The budget outline rightly notes that Social Security's present path is "unsustainable;" the revenues in prospect won't remotely cover the cost of the baby boomers' retirement. But the administration would reduce those revenues. For younger workers, the president wants to partly "privatize" Social Security—transform it into a blend of traditional benefits and personal investment accounts—while preserving the existing system for older workers and those already retired. The problem is how to finance both systems at once. The outline suggests anew that the administration would take at least some of the money for the new accounts from the existing Social Security surplus. But that surplus is already inadequate to cover prospective costs. How, having deepened the hole, would they fill it? Significant benefit cuts is the unspoken answer.

Supplementary savings accounts might indeed be a good hedge against eventual cuts in Social Security benefits. But the right way to begin setting them up is not to draw down Social Security reserves. The surplus general funds that the president would use to finance a tax cut mainly for higher-income people could be used instead to finance savings accounts for families across the board. That, too, would be a tax cut or could be couched as one. It just wouldn't benefit the same people. That's the underlying issue—not a complicated question about the best way to reduce the debt or restructure Social Security, but a simpler one: in dividing up the expected surplus over the next 10 years, who wins?

The Medicare pattern is similar. The hospital part of the program, financed by the Medicare share of the payroll tax, is in surplus. That, too, will disappear when the boomers retire. The budget outline rightly observes that in the long run Medicare will become a major drain on existing resources. Yet once again the administration proposes dipping into existing reserves rather than augmenting them. It would spread the payroll tax even thinner—begin using it to cover not just hospital but other Medicare costs, beginning with a possible new drug benefit. By shifting costs to the payroll tax, it would free up general revenues, thus making it seem easier to finance the president's tax cut. But the Medicare trust fund would go bankrupt sooner.

The administration again says it has no choice; what else to do with the surplus? But the world wouldn't end if it, too, were used for a couple of years to pay down debt, pending the program's possible reform. Modernize the Medicare benefit structure, make whatever structural changes seem likely to make the program more efficient and feather the cost, then finance it. That's when Congress will know how large a tax cut it can afford.

The president is proposing a large tax cut mainly for the rich that would leave the government without sufficient resources to cover enormous costs that his own budget clearly identifies. It's the wrong policy. His administration should tend to the programs first; eat its spinach, then dessert. This budget is the other way around.

Chairman NUSSLE. Mr. Secretary, your entire statement will be placed in the record as you have presented it. You may feel free to present as you wish, and we welcome you and we look forward to your testimony. Mr. Secretary.

STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES

Secretary THOMPSON. Good morning, Mr. Chairman and Ranking Minority Member Mr. Spratt. Thank you so very much for your kind words and all members of the committee. Thank you so very much. It is truly an honor for me to be here.

I was telling the Chairman that I did get sworn in by the President a few minutes ago, and I went to the President and said, hurry it up so I can get up and testify in front of this committee. It's a very short ceremony, made even shorter because of that.

I am honored to be here today, and I am honored to be able to discuss in front of this wonderful committee the framework of the President's fiscal year 2002 budget for the Department of Health and Human Services.

I accepted the position of Secretary of this Department because there is no other job in America where you have a greater opportunity to help people, to actually make a difference and to improve people's lives. The Department's goal must be to build a healthier America by improving the quality of health care, the quality of life for all Americans and reduce health care costs.

President Bush has outlined an ambitious agenda for the Nation, and the Department will play a major role. There are major challenges before us, but I am confident that we will be able to work together in a very bipartisan fashion to successfully meet them. If we are to succeed, we must be willing to reexamine the way we do things on a national level. We must no longer be content with the status quo, because that's how we've always done it.

The HHS budget proposes new and innovative solutions for meeting the challenges that face this Nation. It seeks to enhance the groundbreaking research being conducted at the National Institutes of Health (NIH), modernize Medicare and expand access to quality health care, increase support for America's families and reform the way the Department's operations are managed.

Our proposals also reflect the President's commitment to protecting Social Security and other priority programs, while continuing to pay down the national debt and providing tax relief for all Americans. The budget request for HHS for fiscal year 2002 is $471 billion for all the programs, including $55.5 billion for discretionary programs, an 8 percent increase for the whole Department and a 5.1 percent increase for discretionary programs.

Let me highlight some of our major proposals. One of the top priorities is the National Institutes of Health. The research that is conducted and supported by the NIH offers the promise of breakthroughs in preventing and treating disease from cancer to Parkinson's and Alzheimer's. And I compliment every person on this committee for supporting the NIH budget in the past.

The potential that lies in these projects is why President Bush's plan to double those resources for the NIH by 2003 is so very vital. The $2.75 billion increase is the largest amount ever for NIH. And

it will support the highest level of total research grants in the agency's history.

Of all the issues confronting this Department, nothing has a more direct impact on the well-being of our citizens than the quality of health care. Our budget framework proposes to improve the health of the American people by expanding access to quality health care and beginning to modernize Medicare, including the addition of a prescription drug benefit.

When Medicare was created in 1965, prescription drugs were not the integral part of health care that they are today. Drug coverage was not included as part of the Medicare benefit package. But what was acceptable 35 years ago is simply unacceptable today. As a first step toward remedying the situation, the President has put forward an immediate Helping Hand prescription drug proposal. This proposal gives immediate financial support to the States so that they will be able to provide prescription drug coverage to our neediest citizens.

The President also believes comprehensive Medicare reform needs to be enacted at the same time as the prescription drug benefit. President Bush wants to devote $153 billion over the next 10 years on Medicare modernization that will help improve the financial health of the program and add a prescription drug benefit for all Medicare beneficiaries.

Let me add one thing. As the President said last week in his budget address, every penny of the Medicare trust fund will be used for the Medicare fund, period. We also are proposing steps to strengthen the health care safety net for those most in need. Community health centers provide high quality, community based care to 11 million patients through a network of more than 3,000 centers. The President wants to increase the number of centers by 1,200 over the next 4 years, and he wants to double the number of patients from 11 million to almost 22 million patients through this network. The President has proposed to increase those numbers in this budget.

We propose to increase funding for community health centers by $124 million, which is the first installment in expanding this already successful program. To further increase flexibility and efficiency, we also will work with States to develop ideas that will increase States' ability to expand Medicaid and the State Child Health Insurance Program, more commonly referred to as SCHIP, to cover more of the uninsured.

Within this framework of increased State flexibility, the Administration also plans to work with States to stem the growth of Medicaid costs and be able to ensure the fiscally prudent management of the Medicaid and S–CHIP programs. A former Secretary once said: The family is the original department of health, education and welfare. The name of this Department may have changed, the truth of the statement has not. America's families are its strength, and this Department is committed to doing everything in its power to help better the lives of America's families and their children.

We are proposing a number of new initiatives to help to improve the quality of life of our Nation's families, including a new after school certificate program. We must be willing to invest in programs that support working families in order to move people from

dependency to success in the work force. And one of the most important things that we in Government can do is help working families to assist them in obtaining child care. Last year, the Congress voted to provide a substantial increase in child care funding, and this year, we're asking you to take another step. The President has proposed to dedicate $400 million for after school certificates to help low income working parents to pay for after school care for their children. We expect these after school activities to have a strong educational component, helping children to achieve success in school.

The budget also includes items on promoting stable families and responsible fatherhood, maternity group homes, which is a new program, a compassionate capital fund and a proposal to establish a center for faith-based and community initiatives within the Department. We also will increase funding for substance abuse programs by $100 million.

In addition to funding these priorities, we're making changes at HHS. We must never stop asking ourselves at that Department, how can we do things better. One of the top priorities of this administration and one of mine is improving the management of the Health Care Financing Administration (HCFA). The demands in this organization have grown dramatically in the last few years. We must ensure that it has the necessary resources to successfully administer the Medicare, the Medicaid and the State Children's Health Insurance Program (SCHIP) on which so many people depend.

At the same time, we recognize that patients, providers and States have legitimate complaints about the scope and the complexity of the regulations and the paperwork that govern these programs. During my confirmation hearings, I said that HCFA needs to undergo a thorough examination of its missions, its competing demands and its resources. We're currently in that process of undertaking just that kind of comprehensive review that will make some innovative changes. We will consider any and all options for improving that agency and making it more responsive and an effective organization.

We must also look at the Department as a whole, and HHS will continue to play a lead role in the Governmentwide effort to streamline, simplify and provide electronic options for the grants management processes.

Mr. Chairman, the budget I bring before you today contains a number of different proposals. But one common thread binds them all together. That is a desire to improve the lives of our American citizens. All of our proposals, from enhancing scientific research to modernizing Medicare, are put forward with this one simple goal in mind. I know all this is a goal that is shared by all of you on a bipartisan basis.

I am prepared to work with each of you to ensure that we develop a budget for this Department that effectively serves the national interests. While this is not an exhaustive list of the President's Blueprint, I have outlined some of the President's top priorities for the Department of Health and Human Services.

I would now be happy to answer and entertain any questions that you may have. And I thank you for giving me this opportunity to be here.

[The prepared statement of Secretary Thompson follows:]

PREPARED STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good Morning, Chairman Nussle, Congressman Spratt, and Members of the committee. I am honored to appear before you today to discuss the framework of the President's FY 2002 budget for the Department of Health and Human Services.

As I have noted on other occasions, I accepted the position of Secretary of this Department because I believe that there is no other job in America where you have a greater opportunity to help people to actually make a difference in people's lives and improve the quality of life they lead. President Bush has outlined an ambitious agenda for the nation, and I take great pride in the fact that this Department will play a major role in carrying out his plans. I would be less than candid if I did not acknowledge the vast scope of the challenges that lie ahead of us, but I am confident that we will be able to work together in a bipartisan fashion to successfully meet them.

If we are to succeed in improving the lives of the people of this great nation, we must be willing to take another look at the way we do things on the national level. We must no longer be content to do things a certain way because "that's how we've always done it"; but must instead be willing to reform our business practices and seek innovative ways to manage our programs. And while we know that the Federal Government has an important role to play, we must also recognize that we must look to others to State and local governments, to community faith-based organizations, to academic and religious institutions for new and creative approaches to solving public problems. The President and I share this view, and I am proud to say that it is reflected in the budget framework he has put forward.

The framework I present to you today keeps the promises the President has made and proposes new and innovative solutions for meeting the challenges that face the nation. It seeks to enhance the groundbreaking research being conducted at the National Institutes of Health; modernize Medicare and expand access to quality healthcare; increase support for America's families; and reform the way the Department's operations are managed. Our proposals also reflect the President's commitment to a balanced fiscal framework that puts discretionary spending on a more reasonable and sustainable growth path, protects Social Security and other priority programs, continues to pay down the national debt, and provides tax relief for all Americans.

Mr. Chairman, the total HHS request for FY 2002 is $ 471 billion (budget authority) and $468 billion (budget outlays). The discretionary component totals $ 55.5 billion (budget authority). Let me now highlight some of our major proposals.

ENHANCING RESEARCH AT THE NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health (NIH) is the largest and most distinguished biomedical research organization in the world. The research that is conducted and supported by the NIH, from the most basic research on biological systems to the effort to map the human genome, offers the promise of breakthroughs in preventing and treating any number of diseases. A top priority for this Department is ensuring that the NIH continues to have the resources necessary to help turn these promises into a reality.

To this end, the framework I present to you today includes a Presidential Initiative to double NIH's FY 1998 funding level by FY 2003. For FY 2002, we are proposing an increase of +$2.75 billion, which will be the largest increase ever for NIH. This funding level will enable NIH to support the highest level of total research grants in the agency's history.

With any large increase in resources, there also comes the increased challenge of making sure that those resources are managed properly. I take this responsibility very seriously, and NIH will be working to develop strategies to ensure that we are managing taxpayer dollars in the most efficient and effective way.

MODERNIZING MEDICARE AND EXPANDING ACCESS TO QUALITY HEALTHCARE

Of all the issues confronting this Department, nothing has a more direct effect on the well-being of our citizens than the quality of health care. Our budget framework proposes to improve the health of the American people by beginning the proc-

ess of modernizing Medicare, including the addition of a prescription drug benefit; and by expanding access to quality health care.

IMMEDIATE HELPING HAND

For 35 years the Medicare program has been at the center of our society's commitment to ensuring that all of our seniors enjoy a healthy and secure retirement. But the Medicare program is more than just a social contract between the government and the elderly, it is a commitment that our society has made to our seniors, as well as to the disabled. Honoring this commitment means not only making sure that the program is financially prepared for the wave of new beneficiaries that the aging of the babyboom generation will bring, but ensuring that current beneficiaries have access to the highest quality care.

When Medicare was created in 1965, prescription drugs were not the integral part of health care that they are today and coverage for them was not included as part of the Medicare benefit package. But what was acceptable 35 years ago is simply unacceptable today. As a first step toward remedying this situation, the President has put forward an Immediate Helping Hand (IHH) prescription drug proposal. This proposal gives immediate financial support to States so that they can provide prescription drug coverage to beneficiaries with limited incomes or high drug expenses.

The IHH proposal would complement and build on plans that are currently available in almost half the states, and under consideration in most others. The IHH would be fully funded by the Federal Government and would provide States with the flexibility to choose how to establish coverage or enhance existing plans. Individuals with incomes up to $11,600 and married couples with incomes up to $15,700 who are not eligible for Medicaid or a comprehensive private retiree benefit would pay no premium and no more than a nominal charge for prescriptions. Individuals with incomes up to $15,000 and married couples with incomes of up to $20,300 would receive subsidies for at least half the cost of the premium for high-quality drug coverage. The IHH plan also includes a catastrophic component that would cover any Medicare beneficiaries with very high out-of-pocket drug costs. The President's proposal would provide immediate coverage for up to 9.5 million beneficiaries while we work to enact broader Medicare reform.

The Immediate Helping Hand is a temporary plan to help our Nation's seniors who are most in need of assistance with their prescription drug costs. The benefit will sunset in 4 years or as soon as a comprehensive Medicare reform and prescription drug benefit is implemented. However, this plan is critical because it provides assistance to millions of Americans this year. The President is committed to providing a prescription drug benefit to all Medicare beneficiaries and wants to work with Congress in a bipartisan fashion to see this happen.

The President believes comprehensive Medicare reform needs to be enacted at the same time as a prescription drug benefit. As I have already mentioned, the Medicare program has not kept pace with modern medicine. Today, Medicare covers only 53 percent of the average senior's annual medical expenses and the program's benefits package is lacking. In addition, Medicare is facing a looming fiscal crisis. A full assessment of the health of both the Part A and Part B Trust Funds reveals that spending exceeds the total of tax receipts and premiums dedicated to Medicare and that gap is expected to widen dramatically. Even without the financing problem, Medicare modernization would be necessary to ensure beneficiaries get high quality health care. President Bush wants to devote $153 billion over the next 10 years on urgently needed Medicare modernizations that will help improve the financial health of the program and the addition of a prescription drug benefit for all Medicare beneficiaries.

EXPANDING COMMUNITY HEALTH CENTERS

While modernizing Medicare is the cornerstone of our healthcare agenda, we are also proposing steps to strengthen the health care safety net for those most in need. Community Health Centers provide high quality, community based care to approximately 11 million patients, 4.4 million of whom are uninsured, through a network of over 3,000 centers in rural and urban areas. The President has proposed to increase the number of health center sites by +1,200 by FY 2006. As a first installment of this multiyear initiative, we propose to increase funding for Community Health Centers by +$124 million. We will also be looking at ways to reform the National Health Service Corps so as to better target placement of providers in areas experiencing the greatest shortages.

INCREASING ACCESS TO DRUG TREATMENT

The problems caused by substance abuse affect not only the physical and mental condition of the individual, but the well-being of society as a whole. Nationwide, approximately 2.9 million people with serious substance abuse problems are not receiving the treatment they desperately need. To help close this treatment gap, we propose to increase funding for substance abuse treatment by +$100 million. These funds will be used to increase the Substance Abuse Block Grant, the primary vehicle for funding State substance abuse efforts, and to increase the number of Targeted Capacity Expansion grants, which seek to address the treatment gap by supporting strategic and rapid responses to emerging areas of need; including grants to organizations that provide residential treatment to teenagers.

INCREASING SUPPORT FOR AMERICA'S FAMILIES

William Bennett once said that "the family is the original Department of Health, Education, and Welfare", and while the name of this Department may have changed, the truth of this statement has not. America's families are its strength, and this Department is committed to doing everything in its power to help better the lives of America's families and children. We are proposing a number of new initiatives to help improve the quality of life of our nations' families; as well as to increase support for the charitable organizations that can make such a difference in people's lives.

AFTER SCHOOL CERTIFICATES

One of the lessons I learned during my years as Governor of Wisconsin was that for people to move from dependency to success in the workforce, you had to be willing to invest in programs that support working families. One of the most important things that we as a government can do to help working families is to assist them in obtaining high-quality child care. Last year the Congress voted to provide a substantial increase in child care funding, and this year we are asking you to take another step to help working parents, and their children, be successful. The President has proposed to specifically dedicate $400 million for After School Certificates within the Child Care and Development Block Grant. This would help low income working parents to pay for the costs of after school care for their children. We expect these after school activities to also have a strong educational component, helping children to achieve success in school.

PROMOTING SAFE AND STABLE FAMILIES

Our budget framework takes a number of steps to help protect our most vulnerable and at-risk children and to help them live safe and productive lives. First, we propose a +$200 million increase for the Promoting Safe and Stable Families program, which supports State and Tribal child welfare agencies in carrying out family preservation and support services. These additional funds will be used to help keep children with their biological families, or if it is not possible for them to safely remain with them, to place them with adoptive families. We will also provide an additional $2 million to expand collaborative Federal/State child welfare monitoring efforts. Second, we propose to create a new $67 million initiative within the Promoting Safe and Stable Families program to assist children of prisoners. This initiative will provide grants through States to assist faith and community-based groups in providing a range of activities to mentor children of prisoners and probationers, including family-rebuilding programs, that serve low-income children of prisoners and probationers. Finally, we propose an additional +$60 million for the Independent Living program. These funds would be used to provide vouchers, worth up to $5,000, to youths who are aging out of foster care so that they can obtain the education and training they need to lead productive lives. Funds could be used to pay for either college tuition or vocational training.

MATERNITY GROUP HOMES

One of the toughest problems we face in trying to end the cycle of dependency is children having children. These teenage mothers have often suffered abuse or neglect themselves and may not have a safe and supportive family environment in which to raise their babies. To begin removing the obstacles to success that these mothers and their children face, we are proposing $33 million for a new Maternity Group Homes program. This program will support State efforts to work with organizations that operate community-based, adult-supervised group homes for teenage mothers and their children as well as to provide certificates to young mothers to obtain supportive services. These homes will provide a safe and nurturing environ-

ment for young mothers while offering the support necessary to help them and their children to improve their lives.

PROMOTING RESPONSIBLE FATHERHOOD

Helping young mothers is an important part of our program to assist America's families, but it is also important that we recognize the critical role that fathers play in the lives of their families.

Our budget framework includes $64 million to begin an initiative to promote responsible fatherhood by providing competitive grants to faith-based and community-based organizations that work to strengthen the role that fathers play in their families' lives. These funds will be used to support programs that help low-income and unemployed fathers and their families to avoid dependence on welfare, and to fund programs that promote successful parenting and marriage. Of these funds, $4 million will be used for special projects of national significance.

COMPASSION AND CHARITABLE GIVING

The President has been a leader in recognizing the important role that charitable organizations play in delivering services to the public, and we are proposing a number of steps to increase Federal support for these groups. First, we are requesting $67 million to establish a Compassion Capital Fund. Through public and private partnerships, these resources will be used to provide start-up capital and operating funds to qualified charitable organizations so that they can expand or emulate model social services programs. To complement this Compassion Capital Fund, we also propose to create a $22 million fund to support research on "best practices" among charitable organizations. Our budget framework also includes $3 million to establish a Center for Faith-Based and Community Initiatives in the Department in accordance with the President's recent Executive Order. Finally, we have included a proposal to encourage states to provide tax credits for contributions to designated charities that work to address poverty. Under this proposal, States would be allowed to use Federal funds provided through the Temporary Assistance for Needy Families program to partially offset revenue losses that resulted from the tax credits.

REFORMING THE MANAGEMENT OF THE DEPARTMENT'S OPERATIONS

For any organization to succeed, it must be willing to change. We must never stop asking ourselves how can we be doing things better. But we must also recognize that we do a disservice to all that rely on this Department if we do not provide the resources necessary to effectively administer our programs. In preparing our budget framework, we began the process of evaluating the programs and business practices of this Department and identifying the areas where we can do a better job of managing taxpayer resources, as well as those areas where new investments are required if we are to successfully administer our operations.

HEALTH CARE FINANCING ADMINISTRATION REFORM

One of the top priorities of this administration is improving the management of the Health Care Financing Administration (HCFA). The demands on this organization have grown dramatically in the last few years, and we must make sure that they have the necessary resources to successfully administer the Medicare, Medicaid, and State Children's Health Insurance programs on which so many people depend. At the same time, we must recognize that patients, providers, and States have legitimate complaints about the scope and complexity of the regulations and paperwork that govern these programs. During my confirmation hearings, I said that HCFA needed to undergo a thorough examination of its missions, its competing demands, and its resources. We are currently in the process of undertaking just this kind of comprehensive review, and we will consider any and all options for improving the agency and making it a more responsive and effective organization.

INVESTING IN DEPARTMENTAL INFRASTRUCTURE

The only way that this Department can effectively serve its many clients is if we commit to making the necessary investments in our management and infrastructure. One of the challenges in a large, decentralized Department such as HHS is finding ways to bring together diverse activities and to develop coordinated systems for managing our programs. Our budget framework provides the resources necessary to continue modernizing our facilities, and proposes steps to begin the process of streamlining our financial management and information technology systems so that

we can enhance coordination across the Department and eliminate unnecessary and duplicate systems.

It is critical that we invest in the modernization of the laboratories and office facilities in which many of our most important activities occur. With this goal in mind, we are requesting $150 million to continue a major revitalization of labs and scientific facilities at the Centers for Disease Control and Prevention. We have also included funding for the Food and Drug Administration to finish construction of the Los Angeles laboratory and to continue development of the new headquarters facility in White Oak, Maryland.

For financial management, we propose to invest an additional $50 million to move toward a unified financial accounting system. The Office of Inspector General has cited major problems with the Department's current system structure, which involves five separate accounting systems operated by multiple agencies. We plan to replace these antiquated systems with one or two unified financial management systems that will increase standardization, reduce security risks, allow HHS to produce timely and reliable financial information needed for management decisionmaking, and provide accountability to our external customers.

In the information technology arena, we are proposing $ 30 million for a new Information Technology Security and Innovation fund. Currently, the Department's information technology systems are highly decentralized, heterogeneous, and vulnerable to exploitation. Funds would be used to implement an Enterprise Infrastructure Management approach across the Department that would minimize our vulnerabilities and maximize our cost savings and ability to share information. With this approach, we will be able to reduce duplication of equipment and services and be better able to secure our systems against viruses and network intrusion.

As the largest grant-making agency in the Federal Government, this Department will also continue to play a lead role in the governmentwide effort to streamline, simplify, and provide electronic options for the grants management processes. As part of the Federal Grant Streamlining Program, we will work with our colleagues across the government to identify unnecessary redundancies and duplication in the more than 600 Federal grant programs, and to implement electronic options for all grant recipients who would prefer to apply for, receive, monitor, and close out their Federal grant electronically.

REDIRECTING RESOURCES

Being a wise steward of taxpayer resources means not only recognizing where you need to invest, but also where resources can be redeployed to more effective uses. In preparing our budget framework, we carefully reviewed each agency, identified areas where funding could be redirected, and made targeted reductions in selected programs. Funds for one-time projects and unrequested activities were also eliminated, and the monies redirected to higher priority programs. These decisions, which were made in accordance with the President's overall fiscal goals, will help to moderate the growth of the Department's budget and put it on a more sustainable path.

Last year, Congress took an important step to protect the integrity of the Medicaid program by passing legislation to address the "upper payment limit" loophole, which allowed states to draw down billions of dollars in Federal matching payments for hospitals and nursing homes without any assurance that these payments were used for their intended purposes. But this legislation only partially addressed the problem, because it created a higher upper payment limit for non-State government operated hospitals. Our budget proposes to go even further in closing the loophole, by prohibiting new hospital loophole plans that were deemed approved after December 31, 2000 from receiving the higher upper payment limit proposed in the Department's final rule implementing the upper payment limit legislation.

In addition to taking steps to further address the Medicaid "upper payment limit" loophole, the administration plans to work with States to develop ideas that will improve States' ability to provide quality health care through their Medicaid and State Child Health Insurance Programs. Within this framework of increased State flexibility, the administration also plans to work with States to stem the growth of Medicaid costs and ensure the fiscally prudent management of the Medicaid and SCHIP programs.

WORKING TOGETHER TO BUILD A BETTER NATION

Mr. Chairman, the budget I bring before you today contains a number of different proposals, but one common thread binds them all togther a desire to improve the lives of the American people. All of our proposals, from enhancing scientific research to modernizing Medicare, from expanding access to care to increasing support for

the nation's families, are put forward with this one simple goal in mind, and I know this is a goal we all share.

As you begin to consider our proposals, let me leave you with one final thought. Senator Everett Dirksen said of the legislative process: "You start from the broad premise that all of us have a common duty to the country to perform. Legislation is always the art of the possible. You could, of course, follow a course of solid opposition, of stalemate, but that is not of the interest of the country." Starting from this premise, I am prepared to work with each of you to ensure that we develop a budget for this Department that effectively serves the national interest. I would be happy to address any questions you may have.

Chairman NUSSLE. Mr. Secretary, thank you so much for your testimony.

I would like to dive right into a topic which has been talked about quite a bit on Capitol Hill over the last week, and it involves Medicare and its inclusion in the President's contingency fund as presented in his budget. There has been a very high degree of angst concerning that, and I want to get your take on that. You said in your testimony, and I'd like you to amplify that, my understanding from the President's budget and from your testimony today is that Medicare is for Medicare is for Medicare is for Medicare is for Medicare. Is there anything that you have to change that understanding?

Secretary THOMPSON. I would just add one more, it's for Medicare.

Chairman NUSSLE. It's for Medicare. [Laughter.]

So regardless of how it's called, where it's put, lock boxes, contingency funds, here, there, in a mattress, in a mason jar in the back of my back yard, which I'd certainly volunteer for if somebody would like to put it there, Medicare is for Medicare.

Secretary THOMPSON. That is correct.

Chairman NUSSLE. And it's your intent that based on the President's budget that there be an immediate need for about $153 billion of that for Medicare modernization and an Immediate Helping Hand.

Secretary THOMPSON. That is correct.

Chairman NUSSLE. There is also some who have suggested that if Medicare modernization can move even more quickly than at first it was believed to be able to move, in a much more expedited fashion that in fact more of that Medicare trust fund surplus could be used for that type of reform. Is that correct?

Secretary THOMPSON. That is absolutely correct. The President is adamant about trying to get through this session, and especially this year, a Medicare reform package, one with prescription drugs. What the President and what I'm very concerned about is that the prescription drug proposal is the one that everybody wants to pass. And it's more contentious and more comprehensive and more difficult to pass Medicare reform.

But the President and I personally and strongly urge Congress to work with us on a bipartisan basis to streamline, modernize and make Medicare more efficient, include prescription drugs therein, and give our senior citizens more options. We will work with anybody in this committee or anybody in the Congress to accomplish that goal.

Chairman NUSSLE. If we prepare a budget here on Capitol Hill which segregates the entire HI trust fund surplus into a different sort of mechanism than the President's contingency fund as we

write that budget, would you have any objection to that way of preparing the budget, so that we end all confusion about where Medicare is and should be?

Secretary THOMPSON. Mr. Chairman, the Congress certainly can do that. The administration does not believe that is necessary. But if Congress feels that that is the way to go, we will strongly support you.

Chairman NUSSLE. The administration has not been here long enough to endure the concerns that have been expressed over the last probably six to 8 years involving Medicare and its use. I think it's a well established principle now, particularly in the House of Representatives, that we put that in a lock box and lock it away not only financially, but lock it away politically so that it can't be used for anything else, as well as cannot be used rhetorically against any one particular person or party. I think it would be wise if we construct the budget that way.

I would just like to end my questioning with a question with regard to Medicare reform in general. And I've never been this adamant about a Medicare reform proposal that I'm about to be right now. I've been willing to consider alternatives as a band-aid or as a tourniquet to the situation that we find ourselves in with Medicare as we move forward. But I must tell you, Mr. Secretary, that if I have to go home one more time and present one more Medicare bill that allows rural areas in this country to continue to take a back seat in reimbursement for its Medicare providers, you can count me out of the reform.

I'm willing to step up and do whatever we need to do to modernize this program. I think that all of us on this committee are willing to engage in that. We'll even engage in that, I hope, in a bipartisan way. But I must tell you, we cannot, as far as I'm concerned, this is just one member speaking, proceed with a Medicare program that allows the kind of discrepancy between reimbursements that we have seen over the last years. I would just ask if you share that concern. You may not be able to make it as emphatic as I can.

But do you share that concern? Is this one of the cornerstones or goals that you hope to achieve to try and take out that reimbursement discrepancy that we've seen over the last 10, 20 years?

Secretary THOMPSON. Mr. Chairman, there's no question there's an inequitable situation as far as reimbursement and payment in the Medicare funds. I come from a State like yours that has had those abuses and has had that kind of disparity in payments. But you know as well as I do that formula fights are probably the most contentious of any kind of a fight in Congress. I'm hopeful to work with you on a bipartisan basis in which we will not take from some States and give to other States, because I don't think it's going to pass.

So what we have to do is find ways to infuse some dollars to make more equitable payments, so that we treat more uniformly all the States and give everybody the opportunity to be treated equitably. For that I am very much in favor and am going to work with you and with anybody in this Department to accomplish that. I would take your admonition very seriously and hope that we can work very quickly, hard, on a bipartisan basis, to develop an effi-

cient Medicare system that needs to be streamlined and more equitable. I'm confident we can do that if we're willing.

Chairman NUSSLE. We welcome your partnership in that regard and appreciate your testimony. Now I'd like to recognize Mr. Spratt.

Mr. SPRATT. Thank you very much, and thank you for your testimony.

I think the confusion starts with the New Beginnings budget that was sent up last week. In particular, if you have one available to you, it's Table S1, page 185. That particular table starts by citing the baseline surplus, $5,644,000,000. It then backs out the Social Security surplus, which we've agreed to do for lock box purposes. But there's a glaring omission. Even though the Republican leadership brought to the Floor a bill that had bipartisan support to lock box Medicare, and also back it out, set it aside, this table omits that step.

It then goes on, deducts the tax relief estimate, $1,620,000,000, and deducts several initiatives, $153 billion for the Helping Hand and Medicare modernization, additional spending of $20 billion debt service, and then contingencies, $842 billion, which the President cited in his speech and other witnesses have cited as the cushion fund. The assurance that if these projections don't pan out or spending is higher than projected, the tax cut will end up taking more revenues away, we've still got $842 billion there as a margin of error.

But in truth, that $842 billion contains the Medicare trust fund, the HI trust fund surplus. So that's the reason we're saying, based on Table S1, that you're counting the Medicare trust fund surplus in a general contingency account. It doesn't say contingencies for Medicare. It says contingencies, general contingencies. And witnesses, beginning with the President, have said this is available, this is our assurance that if we backslide and these numbers go wrong, we've got this much cushion in there.

Do you think this chart is in error?

Secretary THOMPSON. I don't think the chart is in error. But I think the conclusion or interpretation may be. I certainly would not say that you're in error, Congressman. What I'd say is that I think there's some confusion. Let me try and explain.

As we all know, Part A of the Medicare fund is going to have a surplus of about $525 billion over the course of the next 10 years. Part B is going to have a deficit of $1,200,000,000. And the President feels that we should streamline all of Medicare, Part A and Part B. It's impossible just to separate Part A and say there's a surplus when Part B, which is also part of Medicare, has a deficit of $1,200,000,000.

But saying all that, the President also has made it crystal clear that the $525 billion is for Medicare. In Congress, there's a law on the book that says that every person is entitled to Medicare, and the only way it could be changed is if Congress would change it. And I don't think this Congress is about to change that.

So that money, whether you call it a contingency or for Medicare, it is for Medicare, and that money will be spent for modernizing and improving Medicare for this country.

Mr. SPRATT. Well, therefore, the general contingency fund has to be reduced by $373 billion, $153 billion you're dedicating to Medicare for Helping Hand and Medicare modernization. You back that out of the $526 billion you get $373 billion. But that money is not for general contingencies. It's just for Medicare, if I hear you right.

Secretary THOMPSON. If the $153 billion is not enough, that money can be used and should be used for improving and streamlining and reorganizing Medicare.

Mr. SPRATT. But for no other purpose?

Secretary THOMPSON. For no other purpose.

Mr. SPRATT. Would you have any objection then if we passed the lock box legislation as we proposed?

Secretary THOMPSON. I am not at liberty to say that, Congressman. That is something that has been decided by OMB to put it in this category. But this money is for Medicare. And the only people that could actually change that are the people in this room and the people in the Congress. I don't think that this Congress is about to do that.

Mr. SPRATT. Well, I think the best thing for this Congress to do is go ahead and pass the legislation, enact the legislation we passed in the House.

One other source of confusion is that you began your testimony and this blue book states that despite statements, despite impressions, Medicare is not in surplus. The HI trust fund is maybe in surplus, but Medicare is in deficit.

I have two problems with that. One is, a deficit implies that the overall amount of money that's being spent in excess of what's being collected from payroll taxes and premiums is a mistake. I mean, we don't intend deficits. In truth, what you're calling a deficit now is a policy designed subsidy, present as a feature of the Medicare program from its very beginning.

So the language of this report, your language earlier, converts a subsidy that was intended, part of our policy, something that comes out of the general fund, we're committing this much out of the Treasury for Part B of Medicare. You take that and use a really pejorative, at least around here, the word deficit has negative connotations. It suggests something that was done wrong, something done by mistake, something we need to correct and reverse, as opposed to the fact that this is really a subsidy we intended all along.

Secretary THOMPSON. Congressman Spratt, I do not in any way try to impugn or make pejorative remarks whatsoever. Let me try and rephrase it.

Part B, over the next 10 years, is going to have more expenditures. If you call it subsidy or you call it deficit, there's going to be more outgo than income, about $1,200,000,000. And you put Part B and you put Part A together, there is less money coming into Medicare than what's going out. You can call it—if you want to call it subsidy.

Mr. SPRATT. You called it a subsidy. We intended it, we designed it. We invented it, it's a feature of the program. It's not a deficit, because that implies that——

Secretary THOMPSON. But the President and the administration and I do not believe, then, that you can truly say that you only can look at Part A and say there's a surplus. We think you have to look

at both Part A and Part B and we think, and I don't want to get into a position of saying you said, I said. I'm here in a very humble way to tell you that we need to fix Medicare.

And I want to work with you, Congressman, to do that. I want to do it on a bipartisan basis. I want to fix both Part A and Part B, and I've got ideas and I know you have some ideas. I would like to be able to sit down with you in your office, discuss them and come up with a solution so we can both walk away from here a year from now and say, you know, we passed a Medicare bill on a bipartisan basis, it's going to be secure for our Senior citizens, there's a prescription drug, there's some options in there. And it's financially solvent for a long time in the future.

That's my goal, that's the President's goal, and that's what we want to do, Congressman.

Mr. SPRATT. I welcome the opportunity. But the language matters. If you say something is a deficit when it's really a subsidy, it matters to the ultimate outcome, how you analyze it.

Secretary THOMPSON. All I can say is I come from Wisconsin and I apologize if I'm not up to speed on your jargon yet, but I will try and learn as fast as I can, sir.

Mr. SPRATT. You were just sworn in a few minutes ago. I doubt that you wrote this. I'm not necessarily directing it at you, I'm directing it at whoever wrote this policy. Because it takes the whole matter, in my opinion, and stands it on its head.

Let me mention one other problem, the light's on and I'll come back later. In 1993, the Medicare HI trust fund was almost scraping bottom.

Secretary THOMPSON. Right.

Mr. SPRATT. Projections showed that by 1999, it would be in a deficit position, a true deficit position, an unintended one. And we added various things to it. We also made reductions in the rate of increase of Medicare payments.

As a consequence, we've been able to build up this surplus in the Medicare HI trust fund. And we've been able to extend the solvent life of that particular trust fund for financing inpatient care until past 2020, a substantial improvement over 1999. And we're pretty proud of that.

But one of the ways we've done it is by saying this money is dedicated to that purpose, and that's the purpose the trust fund served. When I read the statement here, in New Beginnings, it suggests to me that trust funds don't serve a purpose. I think they do serve a purpose. There's a certain fictional aspect to them. But I think by dedicating, earmarking and preserving funds that are intended for a certain purpose, they do fulfill a function.

But if you take what we have accumulated and will accumulate, the $526 billion that we will accumulate additionally for the Medicare HI trust fund over the next 10 years, and use some of that to pay for Medicare prescription drugs, which we all know is going to be very expensive, then you'll only shorten the life of the HI trust fund. When we look at your layout here, we get the distinct impression that what you propose to do is use that trust fund, that surplus, to pay for additional coverage. We propose to use the general surplus to pay for additional coverage, rather than dipping into the Medicare trust fund, shortening its solvent life.

Wouldn't you agree that that's the problem, if you're going to pay for it out of the Medicare HI trust fund, then you've just shortened the solvent life of the HI trust fund?

Secretary THOMPSON. If you don't make any other changes, you're absolutely correct. But if you make the changes and streamline and improve it, there's going to be some efficiencies built in, and that's what I'm hoping for, and that's what the President's hoping for, Mr. Spratt.

Mr. SPRATT. Well, according to your statement in Blueprint for New Beginnings, we've got a $645 billion deficit in this program. Do you think that you can squeeze $645 billion out with reforms?

Secretary THOMPSON. I can't tell you that we can. I can tell you that we're going to try. And I can tell you that I need your help in order to make that possible.

Mr. SPRATT. Well, I'm saying we need your help too by recognizing that if this is to be done, I doubt you can effect $645 billion in cost reductions over 10 years. That is another strong signal that you've got to set aside some of this general fund surplus to be used for Medicare reform, prescription drugs and other things we both say we're committed to.

Secretary THOMPSON. Thank you.

Mr. SPRATT. Thank you very much.

Chairman NUSSLE. Just for members' information, we will be continuing the hearing. There's a vote on, please vote and come back and we'll keep the hearing going.

Mr. Bass.

Mr. BASS. Thank you, Mr. Chairman.

Congratulations, Secretary Thompson.

Secretary THOMPSON. Thank you, Congressman.

Mr. BASS. It's a real pleasure to see you there, and I'll never forget listening to you talk about welfare reform. It was an inspiration in a time when we needed it. It made a big difference in this country.

I also recognize that this is your first hour, if not your first day, first hour, and I don't really think it's proper to go into great detail at this point, except to talk about a couple of things. First of all, I want to associate myself as strongly as I can with the remarks of our Chairman, Mr. Nussle, about the AAPCC formula and how that impacts the disparity in Medicare coverage for rural versus urban and suburban areas in this country. I understand, to use a colloquial term, that this is a food fight. However, it is a problem that afflicts rural districts and rural areas all over this country.

Also, I want to ask you a couple of quick questions about the President's Medicare reform proposal. The Helping Hand is the President's prescription drug proposal, is that right?

Secretary THOMPSON. That is correct.

Mr. BASS. And it is different from his campaign proposal, which was essentially a block grant, is that right? Or is this basically an extension of that?

Secretary THOMPSON. It's basically an extension of that, Congressman, it's more refined than it was in the campaign. But it's basically a block grant.

Mr. BASS. Does the budget submission include funding for both Medicare reform and the Medicare prescription proposal?

Secretary THOMPSON. Yes, it does, Congressman. It puts aside $156 billion—$3 billion this year and $153 billion over the next 10 years—of which $46 billion is set aside for Helping Hand.

Mr. BASS. OK, good.

Mr. Chairman, those are the only questions I have. I'll yield back to you.

Thank you, Mr. Secretary.

Secretary THOMPSON. Thank you very much, Congressman.

Chairman NUSSLE. Thank you.

Ms. McCarthy.

Ms. MCCARTHY. Thank you, Mr. Chairman. I wasn't expecting to be up so soon.

Congratulations on being here.

Secretary THOMPSON. Thank you.

Ms. MCCARTHY. I personally think that you have probably the hardest job among any of your colleagues. I'm a nurse, I spent 32 years as a nurse. Since I've been in Congress, trying to work with HCFA and what's been going on, God bless you. That's all I can say.

Secretary THOMPSON. Thank you.

Ms. MCCARTHY. One of the things that I want to bring up, obviously we all care about Social Security and Medicare. You know with the BBI fix that we had to all of our State hospitals throughout the country, the rural hospitals, certainly my hospitals back on Long Island, in New York State, we tried to help them last year by giving them more money to cover their Medicare reimbursements, to keep up, actually just about the infrastructure of their hospitals.

So with $645 billion that you're talking about, how are we going to keep up the rate of payments back to those hospitals to keep them out of the red, because they didn't have the reimbursements in the past, when we did the balanced budget amendment? We killed them. I mean, the rural hospitals, certainly hospitals we saw closing, our home health care agencies with the red tape that they have. This is a big problem.

I know in my office, I mean, everyone comes in to say they still need help. My concern is certainly taking care of my senior citizens as they get older. We have baby boomers in 2008, which is really coming up, we probably know, anyone that's over 50, each day seems to only have 10 hours a day and not 24 hours a day, because that's how fast time goes.

But we do have some problems. And with the budgets that we're seeing, I really do have a concern that there's not going to be the finances there to do what we're supposed to do. And that is my concern.

How do you see, with the budget that's been proposed, and all the other things that, I actually did read the report, and everything else. What's going to be cut? I mean, there's got to be cuts. There's got to be big cuts somewhere, just to cover the budget.

Secretary THOMPSON. There are going to be some reductions, there's no question about that. We're still working on that, and I'm sure I will be called back in front of this committee to testify when the final budget document is up here. I'm not able to discuss the

reductions as of yet, because we're still arguing over some of them, or discussing some of them, and making decisions.

I would like to point out that I need your help in regards to the nursing shortage that is looming out there, and I would appreciate any comments you might have. Because this is something that is very important to this Department, to try and find a way to get more people enrolled into nursing and take that as a choice in their professions. It's very bad.

Ms. MCCARTHY. I have a bill that I would love you to look at and support that would help my nurses, in recruiting more nurses.

Secretary THOMPSON. I would appreciate that. But there's no question.

But the Department has been treated very fairly when you look at the increases. We got an overall increase, the President tried to hold the increases at 4 percent. And we are going to go up at 5.1 percent on our discretionary funding, and 8 percent overall. That's a very nice increase for the Department of Health and Human Services. I know that the large share of that increase goes to NIH, $2.75 billion.

But we've been able to reduce some other things, such as one-time funding, which was $475 billion. There are some other things, the $155 billion, Congresswoman, that was not requested. And we have made some other adjustments, but we're still working on those. I'll be more than happy to come back and discuss them with you either personally or in front of this committee.

Ms. MCCARTHY. And I thank you for that. But I guess this is the one thing that an awful lot of us are concerned about. Many of us feel that we should actually be doing a budget first, before we have tax cuts that are coming out. I feel very strongly on that, and I come from an area where I'll probably get killed on it, because I happen to love tax cuts. I think I basically have always voted for tax cuts since I've been here.

But when it comes down to looking at our budgets, and even just the budget that you'll be dealing with, and with the tax cuts going first, I'm really afraid that Social Security and Medicare is going to get the short end of it. And I'm really concerned about that. Because if we could deal with something for 5 years out, I could probably live with it. Ten years out, I mean, I just got hit with my oven breaking down. That was not in my budget. Somehow I'm going to have to try and find that money. I've got a 1994 car. It's starting to break down. I'm going to have to find money for that.

You know as well as I do that Government is the same. It's just got billions on the end, or trillions on the end. We still have to do a budget. I really wish we could do a budget first, before we go look at the tax cuts.

Secretary THOMPSON. Well, the President campaigned very strongly on a tax cut. He is a man of principle and he does exactly what he says he's going to do.

Ms. MCCARTHY. Oh, I don't mind that. We're going to get a tax cut.

Secretary THOMPSON. He feels very strongly, as I do, that tax cuts are necessary to stimulate the economy and to improve the economy and I think that you will find that this tax cut, it amounts

to only 6 percent of the overall expenditure outlay. So I really think that we can afford it, Congresswoman.

Ms. MCCARTHY. Thank you, Secretary Thompson.

Chairman NUSSLE. Thank you.

Mr. Gutknecht.

Mr. GUTKNECHT. For the benefit of some of our colleagues, this is the Budget Committee, so I thought I'd share this with them. We were just informed this morning that as of the first 3 months of the last fiscal year, the Federal Government had generated surpluses of $40 billion. As of the first 3 months of this year, we have generated $74 billion in surpluses.

And I think there's going to be more than enough money this year and throughout the balance of the decade to provide for tax relief. So I strongly support what the President is trying to do to allow families to keep more of what they earn. I say that just in response to the earlier line of questioning.

Governor, and I will call you Governor, in some respects I believe that's a much higher title than this one you get to keep for the rest of your life. I have been a big admirer of you for many, many years in the State of Minnesota. I don't so much have a question, but I do have a couple of comments. I think the President has chosen wisely to put you in this position. This is probably, no, I think without a doubt, this is the toughest position at the Federal level, the job that you took the oath of office for this morning.

There are two very huge issues you're going to have to deal with. One is Medicare, and folded into that is prescription drug. And then ultimately, as part of that as well, you have to deal with the whole bureaucracy we know as the Health Care Financing Administration. Those are very, very difficult problems. We want to help you as much as possible.

They are huge bureaucracies. And I want to talk a little bit about what's happening, just so that you understand where we have been and where I have been on prescription drugs. I do believe that we need to totally reform the Medicare system, as the President has talked about, and then ultimately, there has to be included some kind of prescription drug benefit, especially for those people who are currently falling through the cracks. I absolutely believe in that.

But I also believe that if we don't do this right, there is simply not enough money in Christendom to pay for the unlimited demand for free drugs. I want to talk about what's happening, because I'm not certain that the people who work for you in the FDA will give you the whole truth and nothing but the truth about prescription drugs. I will just give you my perspective.

We were able to get a couple of things passed last year. One of them was a small amendment that I had attached to a larger bill that essentially said that the FDA has to, for personal importation, let me explain the situation. And it's not just about Canada. I think we've heard an awful lot about what happens relative to Americans going to Canada to buy prescription drugs, and now there are at least three on-line services that are offering prescription drugs to Americans.

But what's happening around the world, and I'm a big believer in free trade. I believe that trade ultimately is a very good thing.

I also believe that we should not be in the business of setting price controls. But on the other hand, it bothers me greatly that many of these large pharmaceutical companies, who are now based in places like Switzerland, are willing to sell drugs in Switzerland for a fraction of what they're willing to sell those drugs here in the United States.

Let me give you an example. Let's take a drug like Coumadin. Coumadin is a drug that my dad takes, it's a blood thinner, it's one of the most commonly prescribed drugs in the United States. The average price for a 30 day supply in America is about $30. That same Coumadin sells in Switzerland for $3. In other words, it's $1 a pill here in the United States, it's 10 cents a pill in Switzerland.

Now, we have free trade with Switzerland. Goods and services go back and forth across the border, and yet the one area where Americans could benefit enormously with free trade is in prescription drugs. And as a result, there was a lot of confusion about what the law was before. I tried to clarify that.

The issue that I raised, and what my amendment essentially said was, the burden of proof is now on the FDA to prove that that is not a legal drug in the United States. So what we said in the legislation, which the President signed and we now have evidence the FDA is at least moving to try and enforce, we said, you've got to at least tell the consumer what is wrong with the drug that they're bringing into the United States.

So now at least they do cite the fact that, the new letter, and the threatening letters are starting to go out again to seniors. I have a copy of one. Let me just read for you what it says, because you need to be aware of this, as the new Secretary.

The drug that was detained was a drug called Lipitor. The FDA says that the article appears to be a new drug without an approved new drug application. That's what the FDA says in a letter to a senior. Now, if you go to the FDA's own web site, July 1998, they list Lipitor as an approved drug.

Now, on one hand, we're telling seniors and consumers that Lipitor is not an approved drug, when clearly the FDA knows that Lipitor is an approved drug. The argument that you will hear from some of your people within the administration is, well, we cannot absolutely guarantee that that is in fact Lipitor. And do you know what? They're right.

But please bear in mind that every day, millions of pounds of food come into the United States. And it is the Food and Drug Administration. We bring in everything from cheese to pork bellies to strawberries to tomatoes. The truth of the matter is, we don't know whether there couldn't be some kind of adulteration of any of those products. We don't carefully inspect every single tomato that comes into the United States.

It seems to me that the FDA has in effect been helping the pharmaceutical industry for a very long time in protecting them against competition by building a wall disallowing imports as high as the sky, and yet we have a very, very small threshold in terms of drugs. I want you to be aware of that. Because I think there's a powerful case to be made here, and it does begin to fit with what we're doing here on the budget. Let me explain that.

The best estimates that we have is, last year, we the Federal Government, through the Veterans Administration, through medical assistance and other programs which we fund, we spent over $5 billion, minimum, in fact, one estimate is as high as $15 billion, that we spent last year on prescription drugs. If we simply began to open up the markets and allow some competition within the pharmaceutical industry, we could save the Federal Government at minimum another 30 percent.

Now, 30 percent of $5 billion is over $1.5 billion. That would go a long way to helping to solve this problem for those seniors who currently are falling through the cracks.

So I do hope that you'll take an open mind in looking at the legislation we passed last year. There is no such thing as absolutely safe. Even today, in hospitals in America today, and I hate to admit this, but there are patients who get the wrong medication. It happens. So we can never protect everybody from every unforeseen thing.

But I want to close with this point, and this is not a question, but for your own edification, that it isn't the responsibility of the Federal Government to protect consumers absolutely. We can never do that. And in the day and age, a FedEx package, for example, if you sign for a FedEx package, they've got a bar code on that, they know when it was picked up, and at almost any point in the transmission of that package from the sender to the receiver, FedEx can tell you exactly where it is, with bar coding technology. We now have probably the best control we possibly can have in terms of making certain that what left the factory or what left the pharmaceutical supply house in Switzerland will be exactly what comes into this country.

So I really do hope that we can work together, because I think it is a serious problem. I respect the people at the FDA. On the other hand, I think we have to understand that there is no such thing as perfectly safe. We can be within a small fraction of guaranteeing that that is in fact Lipitor that's in that package, and we know that Lipitor is an approved product. If they want to sell Lipitor for 10 cents on the dollar for what they sell it in the United States in other countries, the FDA should not be allowed to stand between American consumers and lower drug prices.

Thank you, Mr. Chairman.

Chairman NUSSLE. The gentleman's time has expired.

Secretary THOMPSON. Congressman, could I quickly just make a couple of statements? First off, I agree with you and I thank you so very much for your understanding. I appreciate the job that you've done. I've watched you right next door, and I'm very impressed by your abilities and what you've been able to do as a Congressman.

But secondly, I want to find out about those letters. Because I personally take Lipitor, and it better be an approved drug, or else my doctor's in trouble.

I would like to see those letters, and I would like to also work with you and I would hope that we would be able to get our FDA director through the process quickly, because we want to make some changes in the overall running of the whole Department, make it much more responsive. And if you've got threatening let-

ters, I would like to hear from you and I would like to take them up with the people. So please give me a copy of them.

Mr. GUTKNECHT. We'll be happy to give you copies. Thank you.

Chairman NUSSLE. Thank you, Mr. Gutknecht.

The gentleman from Washington, Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. Secretary, as you assume the Wisconsin seat on the Cabinet, we hope that we can have as good a working relationship with you as we did with Secretary Shalala.

Secretary THOMPSON. I can absolutely guarantee that, sir.

Mr. MCDERMOTT. OK. I want to pursue something that Mr. Spratt talked about, in part because I sat on the Medicare Commission for a year and went through that whole process.

Secretary THOMPSON. I know you did.

Mr. MCDERMOTT. I know that you as you assume your job are assuming a job of a trustee. And one of the things of a trustee is to report immediately to the Congress whenever the board is of the opinion that the amount of the trust fund is unduly small. That's a heavy responsibility that you have.

I have behind me this chart which illustrates what is going on in this budget book. On page 14 of your budget document, you state that Medicare as a whole is in deficit over the next 10 years for $645 billion. Those are your—that's the administration's figures.

Then if you turn to page 51, you say you can address Medicare's existing problems plus add a prescription drug benefit for only $156 billion between now and 2011. Now, I understand that you're including modernization or some kind of change in Medicare. That's inherent in that statement.

I would like you to tell us how you're going to save the 400 and some odd billion dollars, $489 billion. Is it increases in payroll taxes? Or is it cuts to payments to providers? Or is it cuts of benefits? I mean—or maybe bigger copays? Where are you going to get $489 billion? To have put that together and said it's there, it's nice. I've been doing this a long time.

Secretary THOMPSON. I know you have, Congressman.

Mr. MCDERMOTT. I like specifics. I want to know what percent you think you're going to get from cutting providers when we do our reform of Medicare, or what benefits are we taking away, or what copays are we increasing? Or are we simply going to go out and raise the payroll taxes? Some place you have to come up with the difference between this and that. That's $489 billion.

Secretary THOMPSON. Congressman, first off, let me tell you that the President believes we should take a look at the total Medicare package, both Part A and Part B, and that he does not feel you can just separate and say that you've got a surplus in one and that you've got a subsidy, to use the words of Congressman Spratt, in Part B. We have not, the administration nor my Department, has sat down yet or has had the time to do so, Congressman, to really be able to answer your question specifically. We do not know if there's going to have to be any of the things that you've said. We do not know what we're going to be recommending as a Medicare reform. I can tell you we've been having meetings and the meetings have been going well. But there has not been any definitive decisions as to any of the things you've mentioned, or any other

changes in Medicare that might be able to bring you that kind of savings.

I know you like specifics. I like specifics. But I can tell you that we're not there yet, and that's all I can answer at this point in time.

Mr. MCDERMOTT. You were Governor for 14 years, I was the ways and means chairman in the State of Washington and I wrote five budgets in a row. So I know a little bit about it, and so do you.

Secretary THOMPSON. Yes, sir.

Mr. MCDERMOTT. What other places could you come up with money if you don't cut benefits, don't cut providers, don't increase copayments or increase the taxes that are going into it? What other way could you fill that gap?

Secretary THOMPSON. There are the possibilities, Congressman, that we have to completely look at Medicare, look at the ways in which we're going to use the tax code, look at ways we might infuse some new dollars. I don't know what they would be. I do not know at this point in time how we would make those changes. I can tell you that we're working on them, and I'll be coming back to discuss it with you and to the other members on this committee as soon as we are able to come up with our final package. Hopefully that will be soon, but I can't at this point in time tell you when it's going to be.

Mr. MCDERMOTT. I hope that your package comes up before we pass the tax package.

Secretary THOMPSON. I'm not saying that it will.

Mr. MCDERMOTT. Because if we're giving all the money away and it comes up that you need some dough, I'm afraid where it's coming from. I think that's why many of us are opposed to the President's or the Congress's rush to pass the tax cut before you see this budget. Because if it turns out in the end that you want to reduce the payments to providers, I think the medical association and the hospital association all ought to have a chance to come in here and say, hey, wait a minute.

Secretary THOMPSON. I'm sure they will.

Mr. MCDERMOTT. We did that in 1997, and we've been adding back every year since because of cutting too much. I think it's very clear to everybody on the committee, you have not got the facts, the details. I didn't expect you would. And my feeling is we should not be moving with a tax cut until we have the facts.

I want to just ask one other question. I know that as Governor, or in the past at least, you have been supportive of the use of stem cells in research for Parkinson's Disease and for Alzheimer's disease and spinal cord injuries and diabetes and a whole other category of illnesses. When you came in, or perhaps the administration—I don't know how much of a part you played in it, was to bring into question whether the stem cell research at the National Institutes of Health is going to go on.

I would hope you would look at that very, very, very carefully. Because the only hope for most of those illnesses is some continuing research about how you can take early stem cells and recreate or redo brain cells or spinal cord cells. I think that it would be a terrible mistake to roll back the provisions of the order of the President, the last President. I think that it is very important, and

I hope that you will at least take this guy's view of it into mind when you do it. Because I think it would be a serious mistake to say to the National Institutes of Health, stop the research in these areas.

Secretary THOMPSON. Thank you very much for your advice on both subjects, Congressman. I will take all of your comments very seriously. I would like to point out that I believe that the President is correct that we can have both Medicare reform, save money, and have a tax cut. That's number one. Number two, I am taking my decision very seriously on stem cell research. I am somewhat concerned about the legal opinion that allowed NIH to proceed based upon the Federal law that now exists in this country.

But I am seriously considering it. I will take your admonitions to heart and I will continue to do so, because I believe very strongly in the need for research.

Mr. MCDERMOTT. Thank you.

Chairman NUSSLE. Mr. Thornberry.

Mr. THORNBERRY. Thank you, Mr. Chairman.

Mr. Secretary, over the next few weeks, you and all of us are going to hear a lot about Medicare funding from various accounts. It is in large measure a political tactic to try to scare people about Medicare to attack the tax plan. We know that that's coming and we're going to hear a lot more about that. But I have to tell you, I am conducting my town meetings this year on health care. I believe that the challenge for you and us and Medicare has really less to do with how much money we put into it than what the system is like.

Just thinking about some of the comments made to me this past weekend, one lady in tears who is a physician's assistant's wife, because they're putting their house on the market, not just because of low reimbursement rates in a rural area, but because they have not been reimbursed for several months. They're too afraid to come to my office for help, because they have been threatened in some way or another. A doctor, who's a leading cancer doctor, knows of a treatment they use at M.D. Anderson down in Mr. Bentsen's district, but yet HCFA prevents them from doing that same treatment except on an inpatient basis where it is of course far more expensive to do.

All sorts of providers talk about requiring to change the billing codes by a certain date and then HCFA didn't have theirs changed by that date, so they had to go back and resubmit everything. The list goes on and on. I guess with your considerable reputation for reform and some of the very good people you've got working with you, are you going to look at this thing from the ground up? Because a lot of people who have looked at this believe that we've got to scrap HCFA and start from scratch.

Secretary THOMPSON. Thank you very much for the question, because I have many ideas in regards to what we have to do. There's no question, in my prior life as Governor, I was probably one of the biggest critics of HCFA in this country. I have come out and I have spent a day out on the campus at HCFA, looked it over, talked to a lot of people. The first thing I have to have is my HCFA director confirmed by the Senate and put in place.

Number two, this Congress, and I'm not being critical, this Congress has put a lot more responsibility on HCFA in the last 5 years. HIPAA alone is adding lots of rules and regulations with no increase in personnel and very little increase in resources.

Number three, the resources at HCFA are not what you would call modern day. I don't know if this Congress knows about this, but HCFA spends $375 billion and they do not yet have a double entry bookkeeping system. It is unheard of to think that an agency that runs the largest health insurance company in America doesn't have a double entry bookkeeping system. That went out in 1911, and HCFA is still using a single entry bookkeeping system.

Number four, the computer systems at HCFA need to be modernized. I don't know if this committee knows it, but we have over 200 different computer systems in the Department of Health and Human Services, several that cannot talk to one another. And we're running a department with that kind of equipment.

Number five, HCFA's got some great people. They've got a lot of responsibilities. We've got to time the rules and the changes in those rules either on a quarterly or semiannually or an annual basis, instead of sending them out and saying, oh, we made this rule last week, and because you didn't know about it, that's your problem. We should be able to put it out there so the patient, the provider, the States and this Congress knows that this rule is coming and it's going to change prospectively instead of retroactively.

Number six, we have to make sure we take a look, and maybe HCFA's got too much responsibility. Maybe Medicare and Medicaid should be split. Maybe SCHIP should be in a different area. These are things we want to look at.

I want to come back with a whole litany of changes. Because when I was going through the confirmation process, Democrats and Republicans and Independents alike, everybody came to the same conclusion. Everybody loves to hate HCFA. And I told the people at HCFA, maybe we should even change the name. What is a HCFA? [Laughter.]

So I've got lots of ideas. I want to make lots of changes. But I'm going to have to have the support of this Congress in order to do it. First thing, we've got to have a double entry bookkeeping system. Secondly, we've got to have a computer system that everybody can tie into, the providers and the Department as a whole. Then we have to put the rulemaking on a different plateau than what it is.

If we can make those changes with a new administrator, I'm confident you're going to see a change of attitude and a change of direction at HCFA. I am dedicated and passionate, as you can tell, to accomplish that, Congressman. Thank you for the question.

Mr. THORNBERRY. Well, thank you for your answer. That's the most encouraging news, just seeing the fire in your eyes, that I've seen in quite some time. I've got some proposals that I'm introducing this week to deal with the paperwork requirements. Have your folks come up with an estimate as to how much of our health care dollar in Medicare is consumed by paperwork or regulations, either from the Government side or from the provider side?

Secretary THOMPSON. I've heard anecdotally that it's 18 to 19 percent. But I can't come here and say to you, Congressman, that

I know for a fact that it is. But I've heard that. I've heard it as a Governor. And I'm sure it is high.

But another thing, and I'm going to throw this out here, and it's probably not the place to do it, but it needs to be said. When Medicare was passed in 1965, there was a deal made that the Blues, which I have a great respect for, are the only ones that could provide the vendor payments. Therefore, you're limited in the Federal Government, to contract with other providers.

There are a lot, as everybody knows, there have been a lot of changes in the computer system. Just that one change, and maybe reduce the number, but that also is contentious. I'm throwing it out there because I would like to get people to start thinking about this. There need to be some changes in how we contract. But HCFA is limited to who they can contract with. I think you want the best product, the best service, which I do, and I think we should not be limited to who we can contract with.

Mr. THORNBERRY. Thank you, Mr. Chairman. Good luck, Mr. Secretary.

Secretary THOMPSON. Yes, lots of luck, everybody says. [Laughter.]

Thank you.

Chairman NUSSLE. Mr. Bentsen.

Mr. BENTSEN. Thank you, Mr. Chairman.

Mr. Secretary, it's good to see you today. I have a few questions. One, I'd like to ask for the record, and then I'd like to get back to what Mr. McDermott discussed. Also, at the outset, I want to echo what Mr. McDermott said about the stem cell research. I had a 10 year old constituent, Carolyn Rolley, from my district in my office the other day. She suffers from juvenile diabetes. Her parents are very concerned about whether or not your agency is going to overturn the previous administration's executive order.

So I would hope you'd take a hard look at that.

Secretary THOMPSON. I'm going to, Congressman.

Mr. BENTSEN. I appreciate that.

Second of all, for the record, the President's budget blueprint talks about changes in health professions funding. And I assume this may well include things like medical education, graduate and indirect medical education. That has tremendous impact on the teaching hospitals of this country, including those in my district. I would like to get for the record from your office what ideas you all have in mind and whether you're looking at a different funding structure, whether you're looking at a universal funding structure or what. When those of us who represent large medical centers, read something like that, it raises a few flags.

Secretary THOMPSON. Congressman, that decision has not been finally made yet, but it will be made relatively soon.

Mr. BENTSEN. And it's a difficult question.

Secretary THOMPSON. It is.

Mr. BENTSEN. It's something that Congress has been grappling with for quite some time. As you probably know, we ratcheted it down in 1997, we've been ratcheting it back up since then. But we still have a somewhat inefficient funding structure in that area.

Secretary THOMPSON. Thank you for that background information.

Mr. BENTSEN. Going back to the whole question of the Medicare trust funds, I appreciate your comments today that the Medicare funding is only going to be used for Medicare. I will tell you, you may want to talk to your OMB director. Because his comments last week really do not comport with your statement. And quite frankly, the President's budget blueprint, which I know you're familiar with, does not either.

I want to walk through some of the numbers with you, if I could. And I know you're new on the job, so I'm not going to hold you to it too much.

But both to use your comments that Medicare is for Medicare, and to use the logic that the OMB director and the President had and you echoed today, that you should look at Medicare Part A and B together, Federal law notwithstanding, and in fact, the OMB director last week didn't seem to understand that it would take Congress to change that law. I think you made that clear today.

But the fact is, the President's budget doesn't show a $500 billion future trust fund surplus, which are encumbered funds to future beneficiaries. So if we back that out of the $842 billion contingency fund, that leaves us with $342 billion left there.

Now, the $153 billion that's the Medicare modernization, my first question is, does that come out of those trust fund receipts? The question I have for that is——

Secretary THOMPSON. No, out of that $526 billion?

Mr. BENTSEN. Yes.

Secretary THOMPSON. No. It does not.

Mr. BENTSEN. It does not?

Secretary THOMPSON. No, it doesn't.

Mr. BENTSEN. So I think really for mathematical purposes or accounting purpose, we need to back that out of the $342 billion that's left in the contingency fund. That leaves us $186 billion. Now, this would——

Secretary THOMPSON. Can I just interrupt? I'm sorry, I don't understand why you would back that out. Because that is over and above the $526 billion.

Mr. BENTSEN. You're right, I take that back. It's a separate line item in the President's budget.

Secretary THOMPSON. Right.

Mr. BENTSEN. The point being that the President's contingency fund, if you take out the $500 billion, is down to about $350 billion. If you take out the extra $150 billion that we're spending on the income tax reduction bill that's up this week, because it was scored higher than what was assumed in his budget, we've really chopped that contingency fund down to very little. So I think that's a problem we have to deal with.

Now, I want to go back to the long term reform issues that you talked about. If you take the $500 billion and use that for reform rather than pay out obligations that are against that $500, because that is encumbered money, would you agree?

Secretary THOMPSON. That is.

Mr. BENTSEN. So how do you reform the system in the future if you use that money and are not double counting it without a, cutting benefits, b, raising taxes or copayments or premiums, or c, incurring additional debt in the future? Because as you know, in your

own experience as Governor of a State, once the funds are encumbered, you have to make them up somewhere down the line. I think that's the concern. And I appreciate the fact that the administration wants to reform Medicare, wants to streamline Medicare, and at the same time, add more benefits to it.

But I think you'll be familiar with the experience that we've had in the Medicare Plus or Medicare Choice program, where we wanted to give recipients more options under Medicare, bring HMOs and managed care entities into the Medicare system. What we found is, they couldn't survive in the system, they started backing out, and the only way we could keep them in there was to pay them more money.

So what I'm trying to figure out is, even double counting the $500 billion to use that for reforms, how do you make up that money in the future? And how do you plan to streamline the system? I know you said you haven't written a plan. But do you all really think that you can get efficiencies equaling $500 billion or more if you use the trust fund balances.

Secretary THOMPSON. I can't answer that at this point in time, Congressman. I wish I could. And I don't want to come here and sound evasive, because I'm not. You're going to find that I'm very candid and I'm very direct. But the plan has not been put forth. It has not been scored. We're working on it. But I am encouraged by what we've been able to see that we can make some efficiencies in Medicare.

And I have been very encouraged, both yesterday in the Senate Budget Committee and today, that there seems to be a lot of bipartisan spokespeople that are willing to look at Medicare and find ways to reform it. I think we should dedicate ourselves this year to do that. I can't tell you how we're going to save that amount of money. I can't tell you what benefits are going to be added or changed at this point in time. I wish I could, but I can't. All I can tell you is, this administration is dedicated to reform and streamline Medicare with prescription drugs included.

Mr. BENTSEN. Would you agree with this, we can only count the $500 billion once?

Secretary THOMPSON. Absolutely.

Mr. BENTSEN. Thank you. Thank you, Mr. Chairman.

Chairman NUSSLE. Mr. Sununu.

Mr. SUNUNU. Thank you very much, Mr. Chairman.

I want to begin on that point, Mr. Secretary, because I think it's worth repeating, that the degree to which this administration is committed to modernizing the Medicare system, and to talk about real reforms and real changes that I hope and I believe will result in more choices for beneficiaries, and a better working system. And the administration recognizes that it isn't necessarily going to be free.

I think that is a marked step from where we were with the previous administration that believed by just waving a magic wand and saying the trust funds were hereby twice as large as they were previously that we had somehow done something fundamental about Medicare solvency, or more important, about improving the program. I think we are at an historic point, because Democrats and Republicans recognize that real changes are needed.

I also want to touch on some of the phraseology and jargon that has been used today. There was a suggestion that the Part A, which has a surplus in it of, the projection of $500 billion, that that money somehow represents encumbered funds. I don't think that's entirely accurate. It's really a legal authorization that we now have to pay benefits through the Medicare system, something we know we need to do, we will do. But the fact remains that this system, taken as a whole, isn't solvent. It may be that in its original design, there was intended to be a subsidy.

But we need to think about, as legislators, what that subsidy is. And if we take Part A, which has a surplus, it may well have a surplus, but we also know that that surplus and the legal ability to pay benefits is exhausted in 12 to 15 years. So there may be a surplus there, but the fact is, it isn't in any actuarial balance, it isn't safe and sound in perpetuity. In Part B, there has been a very large subsidy by design. But at the same time, that doesn't mean an open ended commitment to run subsidy rates or deficits in the hundreds of billions or trillions of dollars. No one wants a system that bankrupts future generations for the sake of us as legislators or as families.

I'd like you to talk a little bit about modernization at this point. I know you don't have specifics, but in particular, talk about the prescription drug benefit. Medicare Choice, which Mr. Bentsen was talking about, is the one part of Medicare that right now has a prescription drug benefit. And it's the one part of Medicare that at the end of last year we tried to add funding to make that reimbursement rate more fair, to keep people in the system. And even with that additional funding, the providers through Medicare Choice are getting less on average than the cost of beneficiaries who are under fee for service.

I think that that's an idea place to start to help expand the ability of beneficiaries to get access to prescription drugs. My question for you is, what kinds of programs or opportunities have you seen at the State level that you would want to bring with you now to the Federal level as we try to modernize Medicare and in particular add a prescription drug benefit to Medicare?

Secretary THOMPSON. First, Congressman, thank you for your comments. Because you laid it out as well as anybody has ever laid it out, and I applaud you for it. If I misspoke about earmarking, I'm sorry. The truth of the matter is that there is a responsibility of the Federal Government to pay this money to anybody that reaches the age of 65.

The HMO that you're talking about with prescription drugs I think is a big step forward. I would like to see an expansion of that. I would like to see us work on that and make it much more palatable to people to choose. Every State right now is looking at SCHIP, ways to expand that, to develop ways to reduce the number of uninsured in America. In my home State of Wisconsin, we expanded SCHIP with a waiver after it took us 18 months to get that waiver. I'm very appreciative that we finally got it.

But we have been able to have our uninsured drop below 7 percent. I think in Wisconsin, we're either the first or second or third in America for the least number of uninsured.

But other States are doing that. There are a lot of innovative ideas out there that I think this Congress and my Department should take a look at and categorize and come back with a plan to reduce the number of uninsured in America; and do things to refine, streamline, make more options for Medicare, so that people do have a choice.

Mr. SUNUNU. You mentioned waivers under Medicaid and the fact that at least in the recent past it has taken many months, in some cases several years, to get those waivers that would enable States to implement new ideas, new programs for health care, prescription drugs or what have you through the Medicaid program with greater flexibility, to tailor a program to meet their needs. What will the administration's policy be on granting and reviewing waivers and are there any other specific areas where, as a Governor, you saw success in the ability to deliver benefits better through the welfare reform legislation that you might want to carry through to a review of the effectiveness of Medicaid's delivering benefits?

Secretary THOMPSON. First let me talk about waivers. I made a decision that after a period of time, I don't know what that period of time is going to be, if HCFA has not made a decision that it's going to then be reviewed directly by the Secretary's office as to what's wrong, and we're going to comment and we're also going to contact the Governors and the legislators of that respective State to find out why it has not been granted, what the problems are and how we might be able to modify it so it could be granted.

I'm trying to change their attitudes instead of them trying to find reasons to say no, change their attitudes to try to find a reason why it will not work. Since I have been Secretary for 30 days, we have already approved five waivers that I have personally gotten involved in. And, I am personally going to get involved in expediting the waiver process for the Department of Health and Human Services.

In regards to welfare reform, I think the fact that the TANF grants were flexible enough to allow States to try innovative things. Instead of a rush to the bottom, we've seen just the opposite, a rush to the top, where States have come in with innovative ideas to provide welfare services. But more than that, they provide services to help people get off of assistance and into the job market. I think that has really been one of the best social changes in the last 50 years in this country.

Mr. SUNUNU. I appreciate your willingness, and it sounds odd to say, but your willingness to trust people at the State level to make good decisions. Because I certainly believe in that approach. I want to conclude by offering you the obligatory good luck.

Secretary THOMPSON. Thank you. I need that. And I need a few prayers as well, sir.

Chairman NUSSLE. Ms. Hooley.

Ms. HOOLEY. Thank you.

Congratulations on being just sworn in. I also want to associate myself with our Chair when he talked about AAPCC. I'm from a State, Oregon, where we are very, very low reimbursement for Medicare, and looking forward to seeing that bottom brought up.

It really needs to happen, it's just killing us in States like ours and in the rural communities.

I also want to just hope that on behalf of the 1 million children that suffer from juvenile diabetes that you will keep the NIH guidelines in place so we can continue the stem cell research going on, and allow scientists to continue their valuable research in this area. I hope you will support that.

Secretary THOMPSON. Congresswoman, let me point out three things. Number one, your Governor has already been in with legislators on both sides of the aisle talking to me about a waiver.

Ms. HOOLEY. I know he has. I was going to ask you about that waiver, too.

Secretary THOMPSON. It has not been introduced yet, but I think it's got some merit. I want to review that. I've got a great deal of respect for your Governor, and I think the whole opportunity to combine those is sort of innovative. I'm glad you're supportive of it.

Secondly, in regard to——

Ms. HOOLEY. Stem cell research.

Secretary THOMPSON. No, the second was——

Ms. HOOLEY. Oh, AAPCC.

Secretary THOMPSON. Yes. The reimbursement. I want to be crystal clear. I come to this job from my vantage point of being a Governor for 14 and a half years, and representing both an urban and rural State. I've fought very much with the reimbursement formulas, like you are, and like so many people that I've heard today.

But I just want to put a cautionary note in, that we have to find a way so that we don't take from an urbanized State in order to do that.

Ms. HOOLEY. I understand that.

Secretary THOMPSON. Because all that will end up then is a reimbursement fight and nobody wins. I would like to be able to work with you and work with the members of this committee on a bipartisan basis to see if we can't come up with a more equitable formula.

Third, in regards to diabetes, it's going to become epidemic in this country. It's going to become epidemic. I was just down at CDC. I spent a day there. There are so many things out there that we have to do, and childhood diabetes to me is something that we have to address as a Nation.

I don't think the Federal Government, and I'm not being critical, I'm just making a statement, I don't think the Federal Government has done enough on prevention. We have to do more, if we're going to really solve the health care needs of our society, and diabetes is one of them, we have to get into the mode of being more preventive. We have to be talking to people about exercise, about eating properly and correctly.

And that's going to do more to stem the diabetes epidemic that faces this country, and it's going to get worse in the years to come.

I happen to believe very much in research, and stem cell research, there are prohibitions in the law. And I am concerned about the legal interpretation of what's going on right now. I think we have to have a fresh review, which I intend to do, but I am going to do it in a very systematic way, and I'll be back with you,

Congresswoman, to discuss my findings as soon as they are completed.

Ms. HOOLEY. I have just a couple more quick questions. Recent research on brain development for children has shown how important that zero to 3 years of age is.

Secretary THOMPSON. Absolutely.

Ms. HOOLEY. And it highlights really the necessity for quality care during that time. One of those programs, and there are other programs, Head Start has provided comprehensive early childhood development services to low income children since 1965. We know the program works, and yet there are hundreds of thousands of children that are eligible but we don't have any place for them.

Last year, we increased Head Start by 19 percent, which serves an estimated 70,000 children. I want to know if we can count on you and this administration to continue increasing that vital funding.

Secretary THOMPSON. Once again I have to rely upon my past life and tell you, Congresswoman, that Wisconsin was one of the first States in order to put a State subsidy in to Head Start so we could deal with more children. I happen to be passionate about it. I believe Head Start is one of those Federal programs that's worked better than what Congress had expected.

Ms. HOOLEY. It has.

Secretary THOMPSON. And we have to make sure that we take care of that population, because those children are going to be our future leaders. We've got to get them prepared to go to school. And this happens to be something that this President is adamant about. He wants to make sure every child is ready to learn to read when they go to school, and is able to learn. He believes very strongly in Head Start. I think that you're going to find this administration very forceful in improving Head Start wherever we possibly can, building upon the successes that we've had in the past.

Ms. HOOLEY. Well, I am looking forward, Mr. Secretary, to having this administration put their money where their mouth is and to make sure that in fact, more, additional money goes into Head Start. Then just lastly, I know you met with the Governor, I'm glad you brought up the waiver. I hope it doesn't take as long as it took Wisconsin to get its waiver. And I will look forward to working with you on that waiver.

Secretary THOMPSON. Well, I can't act on it until it's first introduced.

Ms. HOOLEY. I understand that. It will be.

Secretary THOMPSON. OK, thank you very much. But I want to make sure that what we do is correct and lawful, which I insist upon. I will expedite waivers.

Ms. HOOLEY. Good. It's a great, innovative program, that has made a difference to our State. Thanks.

Secretary THOMPSON. Thank you.

Ms. HOOLEY. Oh, by the way, good luck. I forgot to say that, I'm sorry. [Laughter.]

Secretary THOMPSON. Thank you very much. I need that more than anything right now.

Chairman NUSSLE. Mr. Kirk.

Mr. KIRK. Mr. Secretary, I represent an area of Illinois just below cheesehead land, in Lake County, Illinois.

Secretary THOMPSON. It's good to see you again, Congressman.

Mr. KIRK. Thank you. I have a question about the administration of Medicare. Let me describe two of my constituents. Jan Vanderhoof lives in Lake County, Illinois, and received notice from the previous administration that her Medicare managed care option was being dropped. Her 1941 dance partner, Col. Erwin Bruckman, who lives in Cook County, Illinois, still has that Medicare managed care option.

Why did they choose managed care under Medicare? Because it offered a prescription drug benefit. So Jan now does not have that benefit. We are talking so much about offering that benefit, but the previous administration dropped her. And Erwin still has it.

The reason for the divide is because we calculate Medicare reimbursement rates based on county boundaries. Those boundaries made sense back in the 1960's, when the city of Chicago would be all included within one county, Cook County. Those days have long since passed, and the city of Chicago now stretches over many different counties.

So I am faced with heavily suburban communities above and below Lake Cook Road, which divides Lake and Cook Counties Everything depends on which side of that road you are on. Above that road, there is no prescription drug benefit, and no managed care option. Below that road, you're still good to go.

Would it be possible to move beyond the outdated county lines to something that would make more sense for the modern suburban reality of America, like Metropolotan-Statistical-Sampling areas, in calculating Medicare reimbursement rates?

Secretary THOMPSON. That's one question that has not been thrown at me yet, Congressman. What you have just indicated seems to me possible, but even more so plausible and something we should look at. I can't give you a definite answer right now, because this is the first time I've heard about it. I'd appreciate it if you'd send me a letter on that or call me, because I'd like to discuss it further.

I'm one of those individuals that loves new ideas. I love ideas, especially on how to change and improve. I say this for the benefit of every person on this committee, if you've got an idea that you would like us to take a look at, please give it to me, and you'll find that most of those we'll be very receptive to. This one seems to be an excellent suggestion.

Mr. KIRK. I'll do that, thank you. Certainly for the suburbs of Milwaukee, I think probably the same thing would be true.

Secretary THOMPSON. Probably. I didn't know that it was a problem.

Mr. KIRK. I'd like to join with my Democratic colleagues also on supporting stem cell research. The key area that seems to offer so much promise is the Edmonton Protocol, co-funded by the NIH and the Juvenile Diabetes Research Foundation. It's my understanding that we have 21 people who have been insulin-free for over 14 months. That is not a treatment for diabetes, that is a cure. I think we are just on the edge of something, as you well know. I think

stem cell research opens up the door. The Edmonton Protocol is probably the best example of where we could go.

Lastly, I wanted to ask you about the GAO report that Medicare was ″high risk.″ For us, we have got an estimate that roughly $14 billion of the $170 billion under Medicare's fee for service payments were improper. Last year, improper payments totaled about $12 billion, amounting to nearly 7 percent for all fee for service payments. You mentioned this in your testimony, talking about outdated, ineffective computer systems. Certainly while we need a commission on Medicare's future. Where do you think the Department will be able to go unilaterally, just on the computer issue and the payments efficiency issue?

Secretary THOMPSON. I don't know if you were here for my answer to another Congressman about what I intend to do at HCFA. I've got lots of ideas, and I don't want to repeat myself because so many members are here.

But the error rate is down, it's down to 6.8 percent. We had made mistakes of $11.8 billion last year. That's unacceptable to me. It's unacceptable to this Congress.

It's going down, it was up to $22 billion 5 years ago, and it's down to about half of what it was. But can you imagine trying to explain to somebody that your Department made $11.8 billion in mistakes? It's something that is unacceptable to me. I was shocked when they told me that.

But the truth of the matter, HCFA's administration doesn't even have double entry bookkeeping system. I was absolutely appalled when I heard that. So we put some money into this budget for what is called an integrated audit system that I hope that this Congress approves.

We have over 200 different computer systems throughout the Department. And a lot of those cannot communicate with one another. How can you run a company that has the largest health insurance company in the world, Medicare, or in this country, Medicare, with a system that has a single entry bookkeeping system and computers that don't work?

Then you limit, on top of that, HCFA from contracting to just a few companies. That to me is contentious, because I'm sure that people are going to say, well, they're the best companies. And I'm not going to argue about that. But the truth of the matter is, everybody should have an opportunity to process the claims and put in a thing. Maybe we've got too many contract vendors. If you want, maybe we should reduce it down to three, four or five, put them on a merit system, you make mistakes, you lose your contract. Something real radical.

Mr. KIRK. Right. Mr. Secretary, I think I for one will be supporting you on that. Competition is the key answer. I also want to commend you on the administration's commitment to NIH and what we're doing there. I think we're really laying the foundation for our country's legacy in the next century.

Secretary THOMPSON. It's an amazing place out there. We are very fortunate in this country to have the best doctors, the best researchers and the best scientists working for the Department of Health and Human Services and directly for the United States Government. We have just awesome individuals, both at CDC and

at NIH, that are doing just wonderful work. I'm very optimistic that right around the corner, we're going to have a breakthrough in one of the major illnesses. I don't know which one it's going to be, and I can't give you a time, I wish I could. But what's going on at NIH to me is just amazing.

Mr. KIRK. Right out at Deerfield, Illinois, we're launching a new anti-AIDS drug, Cyletra, which is far more powerful than the one currently on the market. I know people fighting HIV around the world need it, and it's that kind of innovation that has been sponsored by NIH.

Secretary THOMPSON. Thank you very much, Congressman.

Chairman NUSSLE. Mr. Kirk, you're recognized to offer the Secretary good luck.

Mr. KIRK. And good luck. Or buena suerte, I should say, lots of luck. [Laughter.]

Chairman NUSSLE. Mr. Capuano.

Mr. CAPUANO. Thank you, Mr. Chairman.

Mr. Secretary, let me start right out, good luck. [Laughter.]

Secretary THOMPSON. Thank you.

Mr. CAPUANO. And also my deepest sympathies, because usually those two things go along together.

Secretary THOMPSON. That's true.

Mr. CAPUANO. I'd just like to make one comment before I get into the main issues I want to discuss. I know you and the Department will have something to do with this new faith-based initiative in communities and the like. Having been raised as a Roman Catholic, I feel in many ways that my religious affiliation has been both guilty of and a victim of significant prejudices in the past and currently in this world today. I believe that many people of religious faiths feel that way about their particular religion, and I know that Wisconsin is a relatively diverse State. I know that many of your residents feel the same way.

My only concern when it comes to the Federal Government getting deeply involved with funding faith-based organizations is to make sure that we do not fund faith-based organizations that are discriminatory against other faiths. My faith is my faith, and it's really nobody else's business, your faith is yours. To me, again, this, this budget document is not the place to discuss that at the moment.

But as we get into that, my hope is that everyone in the administration remembers their own personal and their own political experience back home, wherever they come from, because discrimination is not unique to the Catholic faith, it is not unique to the Jewish faith or to Blacks or to Hispanics or to women. Many people that I know have experienced it in one way or another, many of whom have been related to religious issues.

So again, I don't expect that you would disagree with that. But as you go about your particular aspects doing the faith-based stuff, I would hope that you keep that in mind and reiterate it inside the administration.

The issue that I want to pursue again is the Medicare. I think that everyone here understands the difference between A and B. We're all pretty smart about that stuff, we all understand it pretty well. It's very interesting that one of the previous questioners made

a comment that even A, with its surpluses today, is not currently actuarially stable. There are still significant problems right down the road, even with A, never mind B. I found that very interesting.

I accept your comments, and nobody here today has pushed you, I certainly won't push you to tell us today, right now, what you're going to do about Medicare, what your proposals are going to be. We understand that, and that's fair.

At the same time, you cannot answer us how much any of those are going to cost.

Secretary THOMPSON. That's right.

Mr. CAPUANO. If you're going to improve the audit system, it's going to be a cost. Now, maybe the cost will be less than the $11 billion you save, and I'm sure it will be, but there will be a cost. There will be a cost to dealing with teaching hospitals. There will be a cost to dealing with prescription drugs. There will be some costs along the road and if the $11 billion is what we're talking about, $11 billion isn't going to cover the problems we currently have. They might cover the cost that we're going to add. But it won't cover the problems that we currently face in A and B.

Actually, the thing I like best about this budget document is on page 51, where in two different places, there's a discussion about treating Medicare as a whole and treating the solvency of Medicare in its entirety, which I presume to read means A and B together. I agree with that wholeheartedly. I don't think we should be separating the two. None of my constituents know the difference. None of the taxpayers I know that pay it know the difference. They just know we're paying Medicare money and we want Medicare to be safe.

So I accept everything you've said, and I really like the assurances you've given, which we did not get earlier, that these monies that are now currently a surplus in one portion of Medicare will be there to deal with whatever it is that we come up with Medicare. Even if we come up with nothing, dealing with them together. I'm very happy about that.

However, I will tell you that I personally would feel a lot better if this budget document recognized that in writing. There's a hundred ways to do it. There's no one way to do it. We can all disagree on how to do it. Anything that was done here would be good. And I don't see that here. Now, maybe it's here, and I would love to be pointed to where it is in the book, but I don't see it, except the assurances that I've gotten from you. And again, I take you at your word, but you're not the President just yet, and I'd like to hear it from higher.

For instance, one of the options we could have is simply leave it in the Part A trust fund. Just leave it there. Nobody says we have to take it out. Leave it there to take care of the problems that Part A has already been pointed out that you know exist, we all know exist. If you don't want to leave it there, how about having a piece of this budget simply say, OK, we'll take it out of Part A, but we're going to appropriate it, right now, without any discussion, to Part B. There's two trust funds, let's appropriate it into the Part B trust fund.

Again, that's not the only way. You could have, in Massachusetts, we've had several areas, matter of fact, it's a very good finan-

cial tool, to have pour-over trust funds. When you have to much in one trust fund, it immediately pours over to the other. Maybe we should have a piece of legislation saying that would work.

There are hundreds of other options, even a very simple thing like on the table that was pointed out by Mr. Spratt on page 185, simply taking that 800 and whatever it was, $842 billion in contingencies and separating it into two lines, one line for general contingency of whatever the number is going to be, $200 billion, $300 billion, and another line that simply says, Medicare only contingencies. I would feel comfortable with that. Again, I would like more. But that's something. We don't have any of that in this budget document.

And I would urge you, with all I can, to do more than simply give us your assurances. Again, I don't mean to question you on it, but at the same time, you and I may not be here. And we all know that last year, Mr. Greenspan was here last week and he was discussing his concerns with the end of year last year spending frenzy. I think he's right, we did have a spending frenzy last year, I think it's a legitimate concern.

But I also want to point out that the leadership in neither the House nor the Senate has changed since last year. Now, we tried our best to change it, but it didn't change. And if the leadership doesn't change, I have no assurances we're not going to have another spending frenzy.

And I will tell you that though I have absolutely no problem bringing pork home to my district, that's what I'm here for, my district didn't get much of that pork. And if I had some, maybe I wouldn't be complaining so much. [Laughter.]

But it didn't. I have no assurances that we're not going to have another spending frenzy, and there's nothing here that says I won't. As long as there's an $842 billion contingency sitting there that's not earmarked for Medicare, we have the same risks we had last year.

The last thing, since I'm running out of time, that I want to talk about, is simply, I know that before you were Governor you were a State representative. As a member of that legislative body, I would be shocked, I'd be shocked if you or any other responsible member of any legislative body would sit and pass a budget proposal that cannot answer so many important questions, if nothing else, Medicare alone. It simply says, oh, pass a budget, spend all this money, give all these huge tax breaks.

I want to make it real clear, real clear for the 500th time, no one—I shouldn't say no one—I'm not aware of anyone in the House, Democrat or Republican, who doesn't agree with you that there is room for a tax cut, there is room to take care of the debt problems, there is room to take care of Medicaid, and there is room to take care of some of our spending priorities. The problem is, how much are we going to do for each one of them and who's going to get the benefit. That's the discussion. It's not the discussion whether we're going to have it or not.

So my concern is, we're being asked today to pass a tax cut, I guess tomorrow, I just came from another hearing that has more money that wants to be spent for the SEC over at the Banking Committee, financial services. And I sit here today being asked to

pass a budget, never mind the softness of the estimates. I understand that. But I'm going to be asked to pass a budget that says, trust us, put the money under contingency, and trust yourselves, I mean, Congress is at fault as well, we all spend money, that's what we're here for.

And I don't have any of those answers. I would feel much better if this money were either set off to the side, in writing, that's it, and, not just or, and that this budget and this tax cut were to wait a month or two, whatever it takes, to come up with the proposals that deal with such important things, and there's lots of them, but Medicare being the one I'm here to discuss today, and then we can have that debate, knowing that we may agree, we may disagree. But at least we'll know what we're talking about.

I'm afraid that when it comes time to fix Medicare, the money's gone. The money's gone. And I'm supposed to look at most of my constituents, who are going to get a few hundred bucks, at best, 10 years from now, and a tax cut, and say, sorry, you took your money, we don't have the money to fix Medicare. And I don't see anything in this budget that would assure me otherwise, unless that money is completely set aside either legally or at least in writing in the budget. And I would ask that you bring that message back to the administration some point soon.

Secretary THOMPSON. Thank you very much for your comments. And I appreciate the admonitions. I think the Chairman of the committee, Mr. Nussle, said it as well as anybody could say at the beginning of the meeting, saying that this House, your House, is going to pass a lock box. We're not taking a position on that as the administration, but it seems to me that you and Mr. Nussle are on the same hymn book, singing the same hymn, and it's probably going to proceed that way.

So I believe it's in your hands. I'm not in any way being evasive. I just understand and I thank you for your comments.

Mr. CAPUANO. I look forward to agreeing with Mr. Nussle.

Chairman NUSSLE. It may happen a lot, who knows. Thank you very much.

Secretary THOMPSON. Let's hope it's on Medicare reform.

Chairman NUSSLE. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

I'll assure the gentleman from Massachusetts that the proper changes in leadership in this town were made last year. [Laughter.]

Welcome, Mr. Secretary. You've mentioned that this is the largest insurance company in this country. It's also, I consider the largest HMO in this country. It's Government-run, which leaves a lot of room for error and inefficiency. On top of that, the Congress is the one that tries to run it by law. That even creates a worse problem.

It's an entitlement, meaning that if you fit the criteria of the law you're entitled to the benefits under the Medicare. I'm just pleased that President Bush is looking beyond the politics of this program and focusing on policy. I look with anticipation of your recommendations to Congress on how we change that policy to make it more efficient. I understand the six points that you made earlier, and I think those are good points.

I hope the Congress has the will that the President has, and that is, to deal with this issue beyond the politics of it, and get into the actual policy of it. I'm on the Ways and Means Committee, which we will deal with a lot of the Medicare itself.

Folks at home who are insured under this giant HMO understand the program and the threats to the health insurance under Medicare. They understand that the arithmetic won't work. When you look at the ratio of workers today of 3.3 to those who are insured, and 30 years from now it will be 2 workers to 1, those numbers don't work. They won't work. As far as what it's going to cost in the future for this program, I don't think anyone really knows. Because it's an entitlement. The demand based on the law will drive the numbers.

The only way you can change that is not by saying you're going to throw more dollars at it, by looking at the policy itself. In my understanding, from your comments here this morning, and I like what you have done in the past as Governor. We enjoyed working with you in 1995 and 1996, when we were going through the welfare reform on the Ways and Means Committee. I learned then that I was a mean spirited fellow. I heard it every day. In fact, I told a gentleman who was retiring from that committee at the end of that 1996 year that I went to his retirement because I wanted to hear him tell me one more time how mean spirited I am.

Well, really we're not. We're a compassionate body. The President is a compassionate person. But what we're dealing with is an HMO micromanaged by Congress, by a law, and that has to be looked at and addressed in changing the law itself, dealing with the policy. The money will be there. It will be driven by the policy. We have no choice.

Thank you, Mr. Secretary, and I look forward to working with you.

Secretary THOMPSON. Thank you very much, Congressman Collins, for your wonderful statement. I appreciate that and you're absolutely dead on the mark.

Chairman NUSSLE. Thank you, Mr. Collins.

Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

Mr. Secretary, welcome, congratulations and good luck.

Secretary THOMPSON. Thank you, sir.

Mr. MOORE. I've only been here 2 years, so I'm going to be learning with you, but I would like to talk to you for just a couple of minutes about a telephone call that I had yesterday at 3:30 from Mitch Daniels, who appeared before this committee last week and testified in the morning. I think Mr. O'Neill was in the afternoon.

I presume when Mr. Daniels called me yesterday to discuss the President's tax cut proposal, he knew that I had voted for estate tax relief last year, as well as marriage penalty tax relief. He basically said to me, can you be with us on this tax cut. And I said, I want to be direct with you. And he said, please do. I said, I've got a couple of concerns. Number one, I wish we had a budget before we had a vote on a tax cut proposal. Of course, this is the Budget Committee, and everybody here, I believe, is interested in a budget and how the numbers add up before we start either new spending programs or big tax cuts.

Again, I voted for tax cuts, I want to vote for tax cuts again and I think the people deserve it. It's not a question, really, whether we're going to have a tax cut or not, it's how much, I believe.

I said, the first concern is, we don't have a budget. My second concern, I said, is, and this was yesterday, I said Sunday I was watching the news and the weather. They reported that there was going to be, on the weather they projected a 12 inch snow in Washington, D.C. on Monday. It made me wonder whether I'd get back here in time for a tax cut vote on Thursday, which is based on a projection of $5.6 trillion over the next 10 years.

Now, if a weather report can be that wrong in just 24 hours, my question, how reliable projections on the economic numbers are over the next 5 and 10 years. I would ask, I guess, do you share those concerns about the realities of those projections?

Secretary THOMPSON. I share not the concerns, I share the optimism that those numbers are going to be there. I also share the belief that they may be understated. I feel very comfortable with what the projections indicate. Projections can be wrong. They've been wrong in the past.

Mr. MOORE. And they could be wrong this time as well.

Secretary THOMPSON. They could be wrong. But it seems to me that the conservative estimates that have gone into the projections are such that you can feel pretty comfortable with the figures. In fact, I think the error, if there's going to be any, is on the fact that it's too conservative with the projections, and that there will be more money available for all of these programs, tax cut and the budget and Medicare reform.

Mr. MOORE. You know, you were Governor for 14 years in Wisconsin, correct, sir?

Secretary THOMPSON. That is correct, sir.

Mr. MOORE. You know Governor Bill Graves of Kansas?

Secretary THOMPSON. I do, very well.

Mr. MOORE. I'm from Kansas, and I know that the President knows Governor Graves as well. I was over at the White House, invited over there 3 weeks ago Thursday. I told the President at that time that Governor Graves, I'd seen a week before in the interview in the Associated Press with Governor Graves. I believe if he were sitting right here beside me he would tell you that what I'm going to tell you is an accurate representation of what he said to the reporter. I thought he was very candid. He was talking in that interview about projected revenues that were coming into Kansas, he was talking about tax cuts and about funding education.

What the Governor said was, if I had known then what I know now, with some of the shortfalls in revenues our State is experiencing, I would have done things differently in terms of some of the tax cuts we made. What he was saying was, we're having a heck of a time finding money to fund some of the vital education programs in our State. And just by sheer coincidence, that very morning on the front page of the New York Times, Kansas as well as 15 other States and their Governors were mentioned who were experiencing similar difficulties in their States with revenue shortfalls, and their attempts to try to find money to fund some of the vital programs in their State.

Can you understand my concern about these revenue projections, and even though you're optimistic, can you understand my concern?

Secretary THOMPSON. I can understand your concerns, and I have to tell you that Bill Graves is a very good friend and I strongly endorse Governor Graves. I'm new to the Federal system. I've been here for 30 days. You've had 2 years. But when OMB, with their expertise, makes projections, I think you have to rely upon it. Their growth numbers are very conservative. That's why I feel very comfortable and optimistic that they're going to be met, and I think exceeded.

Mr. MOORE. Well, I think everybody here hopes that you're right. And I hope that optimism is warranted. Because if we're wrong, I fear that our country could be in for another 30 years of deficit spending. I don't want that to happen. I know you don't either and I'm sure everybody in this room does not want that to happen.

Secretary THOMPSON. I don't think anybody wants that to happen, Congressman.

Mr. MOORE. Another part of the problem I have, I guess, with the fact that we don't have a budget yet, and that budget's expected in April, is that correct, the detailed budget?

Secretary THOMPSON. That is correct.

Mr. MOORE. I understand the President has recommended in his Blueprint, which we got the day after his speech, an increase in HHS funding of about $2.8 billion, is that correct, for the next year?

Secretary THOMPSON. That is correct.

Mr. MOORE. I think that is equal to the number of the increase in NIH funding, is that correct, sir?

Secretary THOMPSON. It is.

Mr. MOORE. Would that mean, am I correct in assuming, them, or presuming that if the funding for the increase in NIH is the same as the increase for HHS that some of the programs which you may have not targeted as far as a number yet, a budget number yet, because you haven't gone through the process, are either going to be frozen or cut, including shelters for battered women, meals on wheels for senior citizens, low income heating programs, Head Start, Ryan White AIDS treatment and prevention grants, Maternal and Child Health Care Healthy Start, Centers for Disease Control and Food and Drug Administration? Does that mean those programs could be frozen or cut from their present levels?

Secretary THOMPSON. You've made a list there that's very emotional, and I would have to tell you that most of those programs are not going to be cut or level funded. You have to realize that the Department of Health and Human Services budget, has a huge budget. We were able to pick up $475 million just on one-time programs that Congress funded last year that have now met their purpose and are no longer needed. So there's $475 million there.

There's another $155 million that we were able to pick up that were not only one-time, but they were not requested by the Department to continue. So you're almost up to $650 million. Then there are some other things that are going to be level funded, and I'm not here to tell you that they're not. And there are going to be some programs that are going to be reduced from fiscal year 2001 funding.

But you also have to realize the Department of Health and Human Services has been growing at the rate of about 8 percent a year. So there is some massage room in there so that we can do a very good job for all of those programs and continue to provide the services needed for all Americans.

Mr. MOORE. I don't mean to be emotional, but people in this country do depend upon those programs.

Secretary THOMPSON. I know they do, and I intend to give them the best service I possibly can.

Mr. MOORE. Thank you very much.

Secretary THOMPSON. Thank you.

Chairman NUSSLE. Dr. Fletcher.

Dr. FLETCHER. Thank you, Mr. Chairman. We certainly welcome you, Mr. Secretary. The definition that you often hear for luck is when ability meets opportunity. I feel you're going to have some pretty good luck here, so thank you. I applaud the President for the appointment of you as Secretary.

Looking at the leadership, I served in the State House and looked at your work back in the early 1990's in welfare reform. It stood out in the Nation as some of the most progressive and caring legislation to bring people out of the cycle of poverty that this Nation has seen in the last several decades.

I also want to say that as we look at the budget, and as I was looking through the numbers, I see over 5 years, the President calls for about $1.3 trillion in total Medicare budget authority. I'm reminded of last year and the year before when we saw some budgets from the former administration. We had some cuts actually in Medicare, $28 billion 1 year with cuts in outpatient treatment of cancer, renal dialysis, medication, some other things that I think would take us back in time.

Medicine is changing substantially, and the system that was designed in 1965 does need updating, needs improving. There's a lot of room for improving, and the demarcation between A and B is a false demarcation. Many of the treatments, procedures are done as outpatient, and we incur a great deal of cost because some of them are required to be done inpatient now that could be done much more cost effectively outpatient. So I again look forward to your efforts to improving Medicare, because I do think there are some cost savings.

Just to mention some of the other money, I noticed that you spend over in HHS, or has been spent, about $1.5 billion on information technology, trying to keep up all those 200 different computer systems. I would recommend you look at buying a computer company. Their price is low now, you could probably purchase one over a couple years.

Secretary THOMPSON. That's the best idea I've heard all day, Congressman.

Dr. FLETCHER. And maybe update that, bring us in to the 21st century. I think we're ready to cross that bridge now, with the new leadership.

Let me ask you a couple of questions, though . There are some members that have concern about enacting a stand alone Medicare prescription drug bill or program might inhibit us to move forward or take some of the impetus out of reforming Medicare, which is

much needed. What are your feelings about that? What do you recommend?

Secretary THOMPSON. I'm very concerned about it, Congressman, and I know the President is as well. We feel very strongly as an administration that this is a golden opportunity for us, as a Congress, as a country, to reform Medicare, integrate Part A and Part B, make it a unified system, find new options for individuals to purchase, look at ways in which we could expand Medicare plus, and find ways in which we can put it on a more efficient paying system. All of this could be lost if Congress just passes a prescription drug bill. Because that's the Cinderella. It's the beautiful part. That's what everyone wants to pass and go out and campaign on.

Once that's done, is there going to be an impetus by this Congress to do the heavy lifting to reform Medicare? The administration doesn't think so. We've got a once in a long time opportunity to reform Medicare, and let's do it on a bipartisan basis, and let's do it right. I'm confident that we can do it, and I thank you for your support.

Dr. FLETCHER. Well, I'm encouraged to hear that, because I think it is important, we do have an opportunity. Medicine has changed substantially from acute care to chronic disease management as well as prevention. And Medicare obviously doesn't meet those modern needs that have come about because of certainly an increase in technology and an ability we have with drugs like Lipitor, as you mentioned, that prevent disease rather than paying for bypass surgery or something down the road.

Let me ask you about Medicaid. What can we do? There's several States that are having a problem because of Medicaid over-expenditures. Kentucky's one of them. We just increased or got projections that show an increased deficit primarily related to prescription drugs and expenditures, at least in the State of Kentucky.

What can we do from the Federal level? You bring a great deal of expertise, I'm sure, with Medicaid, in your experience as Governor. What can we do structurally or from a leadership standpoint here in Washington to help confront those problem?

Secretary THOMPSON. I think what we have to do, Congressman, is to allow for an expanded waiver procedure on Medicaid, allow States to really manage their Medicaid system and not penalize them. Give them an opportunity to use the best and the brightest individuals in their State to develop programs and plans that are going to administer health care, and be able to do it in a flexible way and not penalize them when they want to do it differently, not have a rigid system. I think that would go a long way.

Oregon has an interesting concept. Tennessee has an interesting concept, and they're making changes to make it more financially solvent. North Carolina just came in with a waiver on Medicaid, and I was able to grant that. A lot of States are trying things differently. Let's give them the hope and the opportunity to do that.

I think you'd be surprised, just like we found in welfare, it wasn't only Wisconsin. It was your State and States like Texas that came up with some innovative ideas that made welfare reform a success in this country. I think we can have the same kind of results with Medicaid.

Dr. FLETCHER. Well, thank you, and I do look forward to working with you to help enact some of these changes. We welcome you to Kentucky, the beautiful Bluegrass State, and thank you very much, Mr. Secretary.

Secretary THOMPSON. I'd love to come down, you've got a beautiful State. Thank you, Congressman.

Chairman NUSSLE. Mr. Honda.

Mr. HONDA. Thank you very much.

Congratulations on your appointment, and as said before, some of us are new, and I am new also.

Secretary THOMPSON. Thank you. We'll both learn together, Congressman.

Mr. HONDA. Being new, though, I guess that allows us to ask some what some people might consider ignorant questions. So let me go about doing this. The budget that I received is called a blueprint. Usually a blueprint is a well defined, very detailed document. This document seems to be more conceptual in its framework.

Given that, you talked about an increase of 8 percent at HHS, in that Department, where is it that we see it, and that must be an average increase, correct, 8 percent?

Secretary THOMPSON. The 8 percent, the biggest——

Mr. HONDA. It's 8 percent growth in——

Secretary THOMPSON. Eight percent growth. It goes from $436 billion, which is the fiscal year 2001 numbers, to $471 billion, a little over $35 billion. That's an 8 percent growth. That's in both the mandatory and discretionary.

The discretionary payments, which go from $52.8 million to $55.5 million is a 5.1 percent growth. That's the discretionary. And the mandatory is where Medicare and Medicaid and SCHIP is. The discretionary is the other programs.

Mr. HONDA. And you're saying that the 8 percent growth is something that you would like to see controlled. I guess my question to you is that when there are needs, and we have to cover the discretionary portion, should we not meet those if we have the revenue? And under the category where it's required funding, we have a trust fund. Should that not be applied to those programs, rather than merging them?

Secretary THOMPSON. That's got to be a decision by Congress. I think the Department of Health and Human Services has received very generous allotments in the last several years. Sometimes over 8 percent, but the average has been for the last, I believe, four fiscal years, I may be wrong in that, but the Department as a whole has grown by 8 percent.

President Bush feels that that is too much growth, and that we cannot sustain that. If we're going to continue to have tax cuts, if we're going to continue to modernize the Federal Government, if we're going to continue to be able to hold down so that Government doesn't continue to keep growing at such an alarming rate, that he felt it was a more sustainable rate at 4 percent. That's what this budget is all about. HHS even is above that 4 percent, and has been generously treated by this Congress in the past. We feel very comfortable in the Department that a 5.1 percent growth is accept-

able and one that we can handle, and deliver the services and make the kind of changes I've been talking about.

Mr. HONDA. I guess that's the dilemma I find myself in, and perhaps someone else has the details. But for us to have a real good discussion on the details that you're describing, it seems to me that we would have to have a full budget before us in order to have this discussion. Is there a time definite that we'll be able to get a detailed budget from your Department?

Secretary THOMPSON. It's my understanding, Congressman, that the budget will be delivered in the first week of April.

Mr. HONDA. April? OK. And so, in general, in the usual process when you were Governor, before anybody talked about having discussions about the amount that we can set aside and return back to the taxpayers, did you not usually have a budget before you first, and then you considered what a tax cut might look like for the taxpayers?

Secretary THOMPSON. I have learned that there are a lot of differences going from the State and being Governor to the Federal level. What works at the State level I guess doesn't necessarily mean that it works at the Federal level or is being done at the Federal level. We at the State level would never have everything included in one budget. We have a capital budget and we have an operating budget and we have a segregated budget. Most States have at least an operating budget and a capital budget.

But the Federal Government for some reason has just one budget, I guess it's always been the way business has been done. I am not questioning that; it just is a different style.

So I don't think you can compare. I'm using that as an example. I don't think you can automatically compare what we do at the State level to the Federal level, because it's completely two different systems.

Mr. HONDA. Thank you.

Chairman NUSSLE. Thank you.

Mr. Hastings.

Mr. HASTINGS. Thank you. I think I'm painfully the last one here, Mr. Secretary. It's good seeing you again.

Secretary THOMPSON. It's always a pleasure seeing you.

Mr. HASTINGS. I just wanted to mention one thing. One other member asked you about projections. That is an inexact science. But just keep in mind, in 1997 we passed the Balanced Budget Act. We thought we'd balance the budget in 2002. And we in fact balanced it in 1999. So your projections go both ways.

What I would like to just talk about briefly is Medicare and Medicaid. I'm one of those States where the formula penalizes, and I spent President's Day recess talking to all my providers. I've done this the last 3 years. So I asked them to come up with, because I keep hearing the same thing, the formula's wrong, I think you're exactly right, it's a political problem, it's pretty hard to do it. If two people sat down and said, we have a high and a low, the easiest compromise is right in the middle, that's not going to happen in a political body like this. So you have to find some structural changes.

I've heard a lot about regulations. But those things are hard to get a handle around, because they're all intertwined. I've asked my

providers to come up with a top 10. I'd be more than happy to share them with you when the time comes.

Because I think there need to be some structural changes. I think what you're doing your idea with prescription drugs and Medicare overhaul, that is precisely the way to go. I look forward to working with you on that.

Since you have been a leader on welfare reform, and you indicated to Mr. Fletcher that perhaps Medicaid, I'm not going to put words in your mouth, ought to be maybe following the same model as welfare reform, are there some similarities that we can look at in Medicare in that regard also?

Secretary THOMPSON. I'm not sure you can, Congressman. I'm not saying you can't, but I'm not sure, because it's a completely different entity. It's completely funded by the Federal Government. And it's controlled by the Federal Government, all the rules and regulations and administration of it is by the Federal Government pretty much. So it's very difficult, I think, to make the same analogy to Medicaid and to welfare from Medicare.

I think you can make the argument that it's got to be much more responsive, it's got to be simpler, and it's got to be much more uniform as it relates to the administration here in Washington than what we've actually seen in the past.

Mr. HASTINGS. Well, maybe something will come out of my effort to try to find regulations that are onerous to our providers that may show a regional or State difference. In other words, central Washington may be a whole lot different than say, Manhattan. Maybe there needs to be some flexibility in that regard.

Secretary THOMPSON. Oh, I didn't refer to rules. I think with rules, we can do a much better job. One of the real problems has been that we have too many rules and they change too often. Then they have some kind of ex post facto result. We have to be prospective, and we have to simplify the rules.

I don't know about you, but I tried to read some of these rules, and I just blank out. I can't understand them. I feel I'm a fairly quick study. So I can imagine what a provider is thinking about, back in Washington or back in New York. I think we can do a better job. That's what I hope to do.

Mr. HASTINGS. You'll discover here when you hear two bells and all this stuff that we have to go vote. I will be more than happy when I gather all this information to obviously work with you to provide some of the onerous rules and regulations.

With that, Mr. Chairman, thank you. I know we have to go vote, and it's good seeing you, Mr. Secretary.

Secretary THOMPSON. Always a pleasure. Thank you so very much.

Chairman NUSSLE. Thank you, Mr. Secretary, for your testimony.

[Recess.]

Chairman NUSSLE. The committee will come to order.

Now we will begin the panel for today's second hearing on the President's Budget for Health and Human Services. This morning, we heard from the newly sworn-in Secretary, former Governor Tommmy Thompson, now the Secretary of the Department of Health and Human Services.

This afternoon, we will focus on welfare in our next panel. I will invite our two gentlemen to come forward to the witness table. We have two leading authorities on the subject of welfare in our country, two that were involved in the welfare debate and reform proposals, certainly from two different vantage points, but nonetheless both well respected in the field. We are honored to have both of them here today.

First, we have Robert Rector, who is from The Heritage Foundation. He is, as I said, one of the leading authorities on poverty and on the U.S. welfare system. He focuses on a range of issues relating to welfare reform, family breakdown and America's various social ills. He played a major role in crafting the Federal welfare reform legislation which passed in 1996 and has conducted extensive research on the economic costs of welfare and its role in undermining families. We welcome Mr. Rector to our witness table today.

We also have Wendell Primus who is a leading authority on welfare as well. He joined the Center on Budget Policy and Priorities in the beginning of 1997 and is the Director of Income Security. As head of this division, he is working to expand the Center's research into areas including Social Security, unemployment insurance, income poverty trends, Federal policy relating to 1996 Federal welfare law.

At the U.S. Department of Health and Human Services, he served as the Deputy Assistant Secretary for Human Services Policy in the Office of the Assistant Secretary for Planning and Evaluation.

We appreciate both of you coming today and I understand Mr. Primus is also going to regale us a little bit with his expertise about Iowa, to which I am looking forward.

I will invite you to testify as you would like. Your entire testimony will be made part of the record without objection. You may summarize your testimony as you see fit and we will proceed from there with questions.

First, I will recognize Mr. Rector. You may proceed.

STATEMENT OF ROBERT RECTOR, THE HERITAGE FOUNDATION

Mr. RECTOR. Thank you.

Today, I am going to speak about total means tested welfare spending and the budget which is a topic we do not hear very much about but I think it is very important to look at the total amount of aid and the total system of providing aid to poor people which the Federal Government currently provides in a holistic manner rather than splitting it up into 20 different little parts which gives you a very misleading picture about its size and its nature.

By total means tested aid I am covering cash, food, housing, medical care, social services, training and directed education provided to low income persons. As I talk, if you have my written testimony, it would be easier if you could look at some of the charts. Particularly now, I am speaking about Chart 2 in my written testimony.

In fiscal year 2000, the Federal Government spent $312 billion on means tested aid to low income and poor people. With largely mandatory contributions made by the State Governments, that

total came to $434 billion, a record high and about 4 percent of our entire economy.

The amount of money we are spending on welfare last year alone exceeds the entire gross national production of this Nation at the beginning of the 20th Century. This spending has grown astronomically as Chart 2 will show.

When Lyndon Johnson launched the War on Poverty, we were spending $8 billion on welfare. Today that figure is now $434 billion. Even adjusting for inflation, welfare spending has increased tenfold since the beginning of the War on Poverty and cash, food and housing alone has increased sevenfold.

If Lyndon Johnson were to return today, look at the welfare state and look at that $434 billion, he would simply be appalled. He would not be able to believe it. He would also clearly recognize that this spending violates the essential principles of what he was trying to accomplish in the War on Poverty.

In launching the War on Poverty, Lyndon Johnson clearly stated that he did not believe in unlimited growth of one-way handouts and in unlimited growth in dependency. He did not believe in having an ever larger growth of people on the welfare system. Instead, his goal was to reduce the behavioral causes which made dependency and poverty necessary. He had a joint goal of reducing poverty and reducing dependency. I would say on both of those goals over the last 35 years, we have largely failed.

The welfare spending growth that we have seen since the beginning of the War on Poverty has continued during the 1990's. Very few people realize that during the 1990's, we actually had a welfare spending explosion. Total spending rose from $215 billion in 1990 to $434 billion in the year 2000. That is a doubling of growth. Even after adjustment for inflation, the growth is at 61 percent. This spending growth is projected to continue under the Bush budget.

If you could turn to Chart 4, it outlines both the growth the during the 1980's and 1990's as well as the projected growth that can be determined from the figures in the Bush blueprint budget. What we see is the total welfare spending over the next 5 years will rise from $434 billion to $573 billion, an increase of roughly one-third. Cash, food and housing will go up by roughly 25 percent.

It is particularly interesting given that the new administration has a priority on defense to compare the defense outlay growth with the projected welfare outlay growth. Defense spending, as you can see on Chart 4, is projected to grow by about 17 percent over the next 5 years. Welfare alone is going to grow by 31 percent. The gap between welfare spending and defense spending will actually go up over the next 5 years.

I think with this amount of money, which I think would stun the average taxpayer, it is very, very difficult for anyone to claim that the proposed Bush budget and tax cuts are in any sense going to constrain or cause cuts in the welfare system. In fact, they do no even slow down the growth of the welfare system in any way whatsoever.

I think if we are interested in controlling the growth of welfare spending, as well as truly helping the poor, we need to look beyond simple spending at the causes of why all this spending is occurring. In Chart 6, I think the major causes are clearly outlined there.

About half of total welfare spending goes to families with children and of that spending, some 70 to 90 percent goes to parents and single families. In fact, as we look at the welfare system as it affects children in the United States today, it is almost exclusively a subsidy system for single parents. That goes for virtually every program that you would look at, public housing, Section 8 housing, TANF, food stamps, earned income tax credit. They are all predominantly subsidy systems for single parents.

The reason that we have the welfare system we have is basically because the out-of-wedlock birth rate in the United States rose form 6 percent when the War on Poverty began in the 1960's to 31 percent today and the divorce rate has also risen. That absolute collapse of marriage creates the economic need for all of the programs which you here on the Budget Committee feel you have to fund because these families do need assistance because of the decline of marriage.

Fortunately, in the budget proposed by President Bush, there is a small new program in there to promote fatherhood which I think could be considerably higher and that program would be a focal point for developing new policies to bring down the out-of-wedlock birth rate, to bring down the divorce rate, and to encourage and stabilize marriage.

In conclusion, I would say if you look at these figures in the budget, it is quite clear that welfare spending is out of control and is going to continue on the present course to rise very, very rapidly for the foreseeable future.

To control welfare spending in the future, we need to do one thing in particular. We need to remove those behaviors which create a need for aid in the first place, specifically, the lack of work and the lack of marriage. If we remove those behaviors, then the need for this great growth in welfare spending will disappear and the client population will be far better off.

Specifically, what we should look at in terms of future welfare policy is requiring work as a condition of receiving aid. That increases employment and reduces poverty. We should specifically encourage rather than discourage marriage. If we could get even a slight increase in the marriage rate and a drop in the out-of-wedlock childbearing rate, we would see welfare dependence drop very, very rapidly.

If we do those things, we will see the rate of spending growth level off, the poverty rate in the United States drop very, very rapidly as it has over the last 3 years due to the TANF reforms and we would also see the well being of children, the most important thing, increase dramatically.

I thank you for your time.

[The prepared statement of Robert Rector follows:]

PREPARED STATEMENT OF ROBERT RECTOR, SENIOR RESEARCH FELLOW, THE HERITAGE FOUNDATION

INTRODUCTION

The U.S. welfare system may be defined as the total set of government programs—Federal and State—that are designed explicitly to assist poor and low-income Americans.

Nearly all welfare programs are individually means-tested.[1] Means-tested programs restrict eligibility for benefits to persons with non-welfare income below a

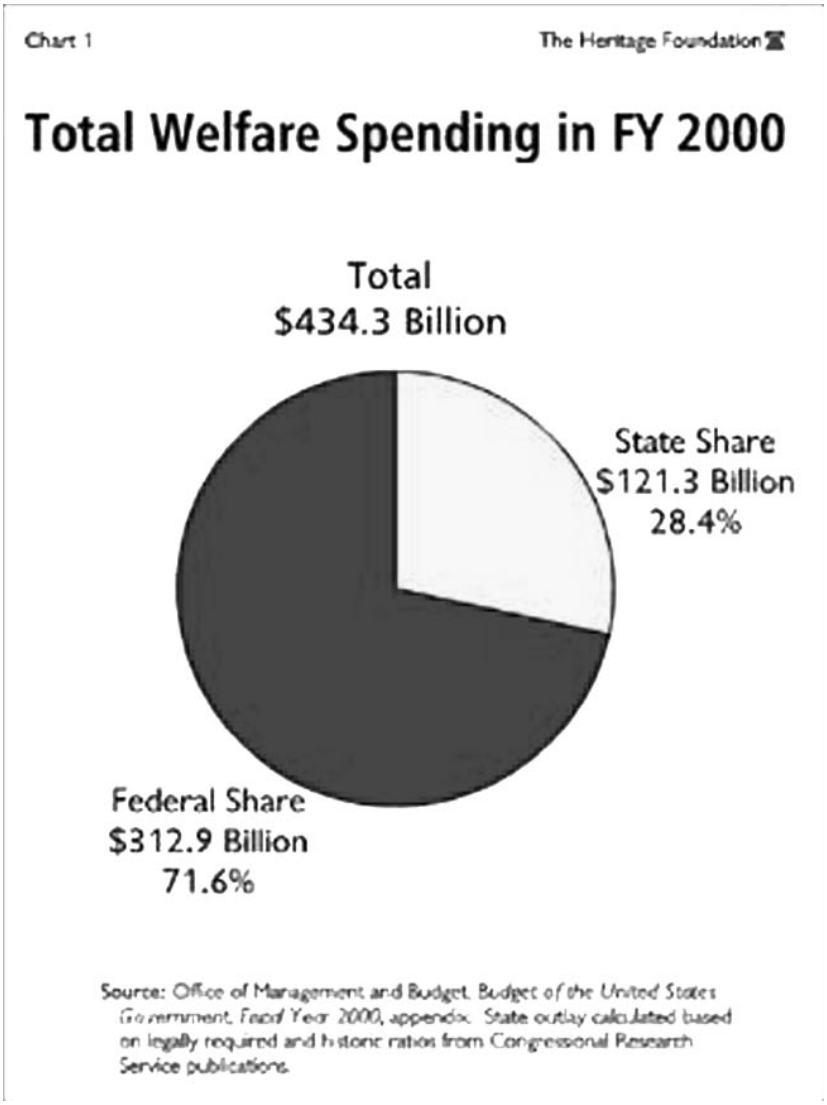
certain level. Individuals with non-welfare income above a specified cutoff level may not receive aid. Thus, Food Stamp and Temporary Assistance to Needy Families (TANF) benefits are means-tested and constitute welfare, but Social Security benefits are not.

The current welfare system is highly complex, involving six departments: HHS, Agriculture, HUD, Labor, Treasury, and Education. It is not unusual for a single poor family to receive benefits from four different departments through as many as six or seven overlapping programs. For example, a family might simultaneously receive benefits from: TANF, Medicaid, Food Stamps, Public Housing, WIC, Head Start, and the Social Service Block Grant. It is therefore important to examine welfare holistically. Examination of a single program or department in isolation is invariably misleading.

THE COST OF THE WELFARE SYSTEM

The Federal Government currently runs over 70 major interrelated, means-tested welfare programs, through the six departments mentioned above. State governments contribute to many Federal programs, and some states operate small independent programs as well. Most state welfare spending is actually required by the Federal Government and thus should considered as an adjunct to the Federal system. Therefore, to understand the size of the welfare state, Federal and state spending must be considered together. (A list of individual welfare programs is provided in Appendix B.)

Total Federal and state spending on welfare programs was $434 billion in FY 2000. Of that total, $313 billion (72 percent) came from Federal funding and $121 billion (28 percent) came from state or local funds. (See Chart 1.)



Welfare spending is so large it is difficult to comprehend. On average, the annual cost of the welfare system amounts to around $5,600 in taxes from each household that paid Federal income tax in 2000. Adjusting for inflation, the amount taxpayers now spend on welfare each year is greater than the value of the entire U.S. Gross National Product at the beginning of the 20th century.

The combined Federal and state welfare system now includes cash aid, food, medical aid, housing aid, energy aid, jobs and training, targeted and means-tested education, social services, and urban and community development programs.[2] As Table One shows, in FY2000:

- Medical assistance to low income persons cost $222 billion or 51 percent of total welfare spending.
- Cash, food and housing aid together cost $167 billion or 38 percent of the total.
- Social Services, training, targeted education, and community development aid cost around $47 billion or 11 percent of the total.

Table 1 The Heritage Foundation

Total Welfare Spending FY 2000
(In Billions of Dollars)

	Federal Spending	State Spending	Total Spending	Percent of Total Spending
Cash	$77.80	$22.78	$100.58	23.2%
Food	34.71	1.34	36.05	8.3
Housing and Energy	28.26	2.12	30.38	7.0
Medical	130.81	90.79	221.60	51.0
Education	22.46	1.34	23.80	5.5
Training	5.79	0.07	5.85	1.3
Services	7.74	2.93	10.67	2.5
Community Aid	5.41	0.00	5.41	1.2
Total	**312.95**	**121.38**	**434.34**	**100%**

Note: Some numbers may not add due to rounding.
Source: Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2000*, appendix. State outlay calculated based on legally required and historic ratios from Congressional Research Service publications.

Roughly half of total welfare spending goes to families with children, most of which are single parent households. The other half goes largely to the elderly and to disabled adults.

THE GROWTH OF WELFARE SPENDING

As Chart 2 shows, throughout most of U.S. history welfare spending remained low. In 1965 when Lyndon Johnson launched the War on Poverty, aggregate welfare spending was only $8.9 billion. (This would amount to around $42 billion if adjusted for inflation into today's dollars.)

Since the beginning of the War on Poverty in 1965 welfare spending has exploded. The rapid growth in welfare costs has continued to the present.

- In constant dollars, welfare spending has risen every year but four since the beginning of the War on Poverty in 1965;
- As a nation, we now spend ten times as much on welfare, after adjusting for inflation, as was spent when Lyndon Johnson launched the War on Poverty. We spend twice as much as when Ronald Reagan was first elected.
- Cash, food, housing, and energy aid alone are nearly seven times greater today than in 1965, after adjusting for inflation;
- As a percentage of Gross Domestic Product, welfare spending has grown from 1.2 percent in 1965 to 4.4 percent today.

Some might think that this spending growth merely reflects an increase in the U.S. population. But, adjusting for inflation, welfare spending per person is now at the highest level in U.S. history. In constant dollars, it is seven times higher than at the start of the War on Poverty in the 1960's.

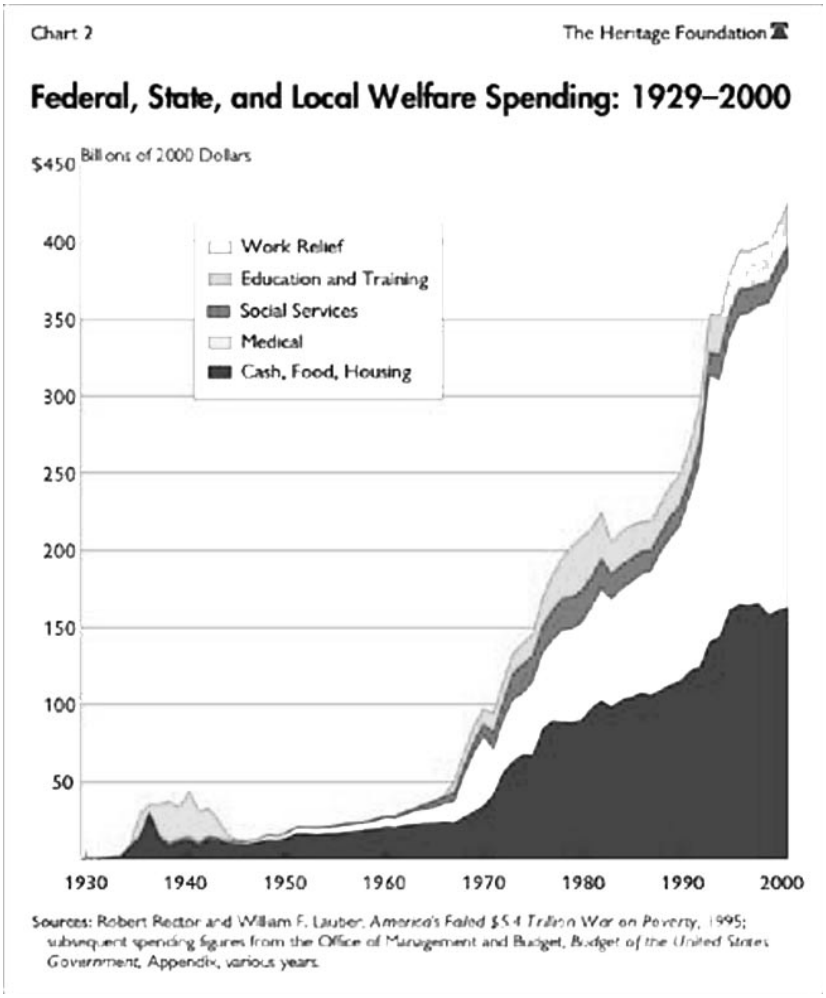
TOTAL COST OF THE WAR ON POVERTY

The financial cost of the War on Poverty has been enormous. Between 1965 and 2000 welfare spending cost taxpayers $8.29 trillion (in constant 2000 dollars). By contrast, the cost to the United States of fighting World War II was $3.3 trillion (expressed in 2000 dollars). Thus, the cost of the War on Poverty has been more than twice the price tag for defeating Germany and Japan in World War II, after adjusting for inflation.

WELFARE SPENDING IN THE NINETIES

Welfare spending has continued its rapid growth during the last decade. In nominal dollars (unadjusted for inflation), combined Federal and state welfare spending doubled over the last 10 years. It rose from $215 billion in 1990 to $434 billion in 2000. The average rate of increase was 7.5% per year. Part of this spending increase was due to inflation. But, even after adjusting for inflation, total welfare spending grew by 61 percent over the decade.

As Chart 2 shows medical spending (mainly in the Medicaid program) grew most rapidly during the 1990's, but welfare cash, food, and housing spending grew as well. Adjusting for inflation, cash, food and housing assistance is 37 percent higher today than in 1990. However, the growth in these programs has slowed since 1995, increasing no faster than the rate of inflation. This recent slowdown in spending is, in part, the effect of welfare reforms enacted in mid-nineties.



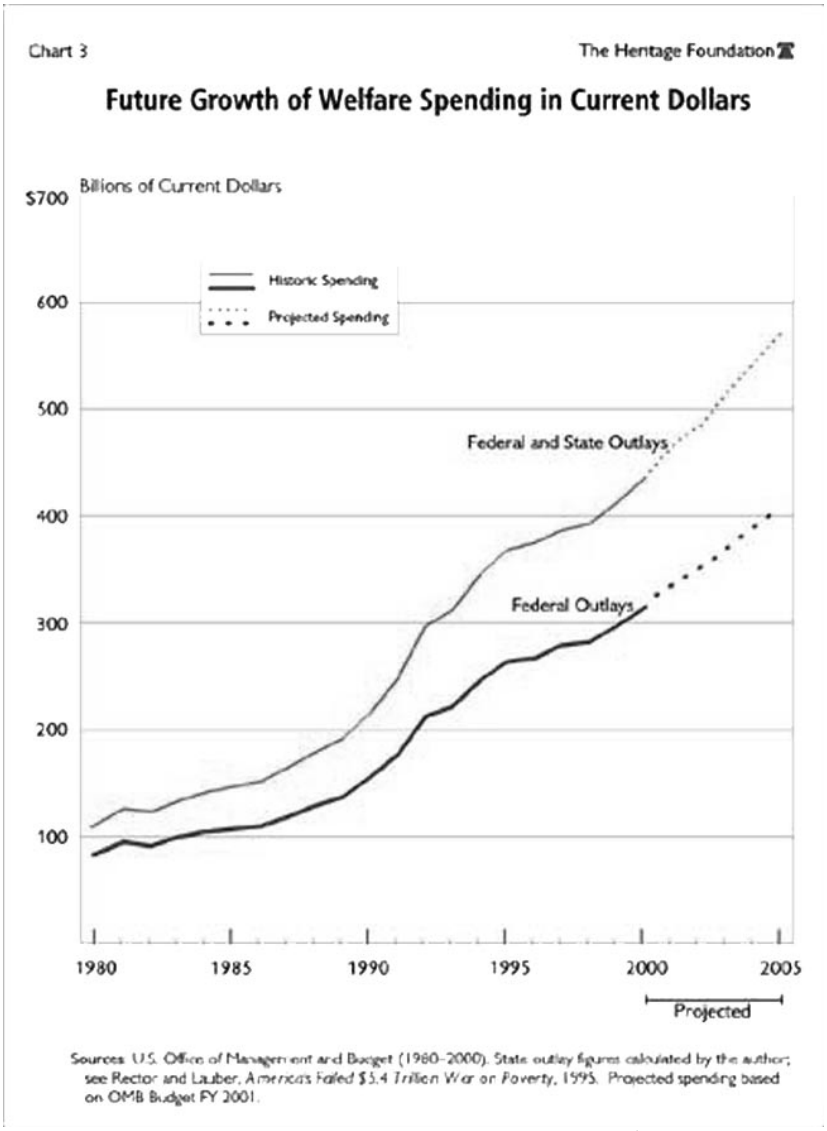
FUTURE WELFARE SPENDING GROWTH

President George W. Bush's recent budget blueprint does not contain sufficient detail to permit projections of welfare spending program by program.[3] However, the budget blueprint does provide spending projections for two major budget functions which are integral to the welfare system. These budget codes are Income Security (Function Code 600) and Health (Function Code 500). Income Security contains cash welfare, Food Stamps and other food aid, and housing aid.[4] Health (Code 500) contains Medicaid and a few smaller means-tested health programs. Between them, these two budget categories contain about 90 percent of the Federal welfare system as it is described in this testimony. (Note: neither category includes Social Security or Medicare.)

President Bush's budget plan allows for spending in Income Security and Health to grow as rapidly or more rapidly than did former President Clinton's FY 20001 budget request. Income Security (Code 600) is scheduled to grow by 24 percent over the next 5 years. Health (Code 500) is scheduled to grow by 62 percent over 5 years.[5]

Based on these figures it seems certain that means-tested welfare spending will grow as rapidly under President Bush's first budget request as under Clinton's last. Projected welfare spending figures from Clinton's last budget (FY2001) are provided

in Appendix A.[6] These figures show a rapid of growth in welfare spending. (See Chart 3.)[7]



• Total Federal welfare spending is projected to grow from $315 billion in 2000 to $412 billion in 2005: an increase of 31 percent. The annual rate of spending increase is projected at 5.5 percent.

• Federal spending on cash, food, and housing aid is projected to grow from $141 billion to $174 billion: an increase of 23 percent. The annual rate of spending increase would be 4.3 percent, nearly twice the anticipated rate of inflation.

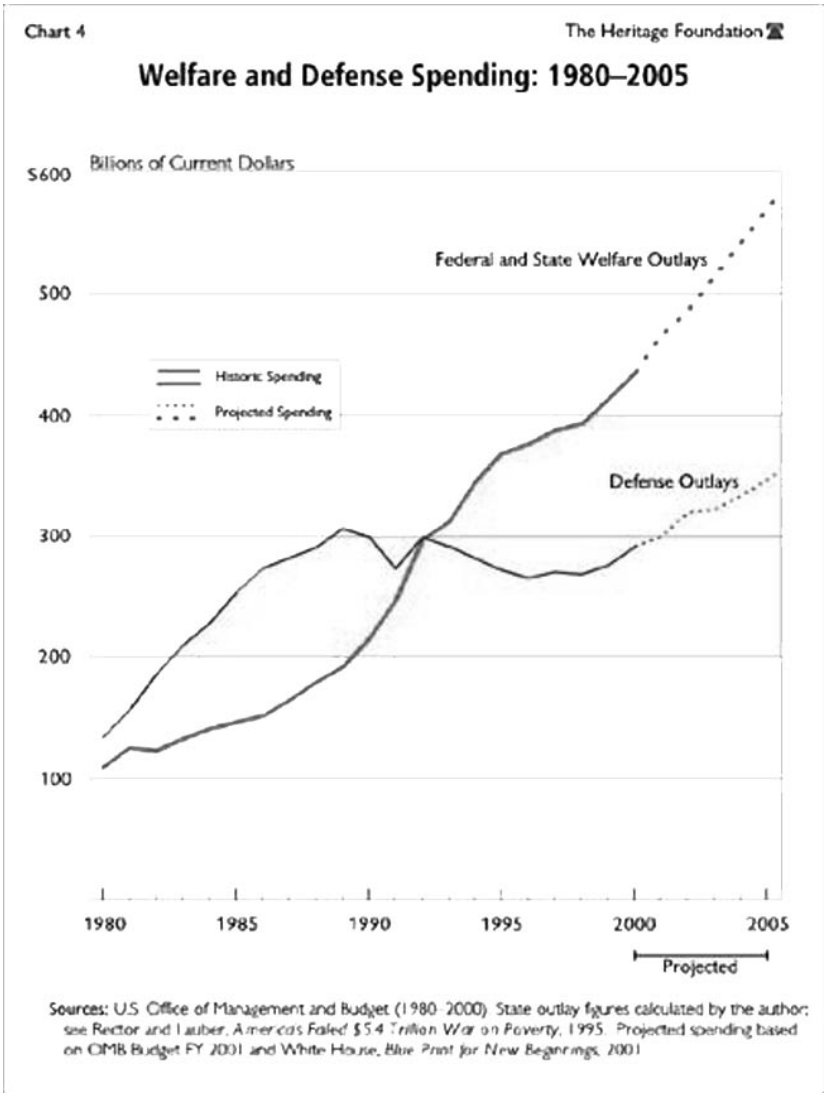
• Together, Federal and state welfare spending would rise from around $434 billion in 2000 to $573 billion in 2005.

Again, although we do not yet have program by program spending projections from the Bush administration, the broad budget function figures we do have allow for the same rate of growth in cash, food, and housing as Clinton's plan. Moreover, the Bush figures would permit more rapid growth in health spending. Thus, clearly,

President Bush's plan does not require cuts in welfare spending or even a slowdown in the rate of spending growth.

WELFARE AND DEFENSE

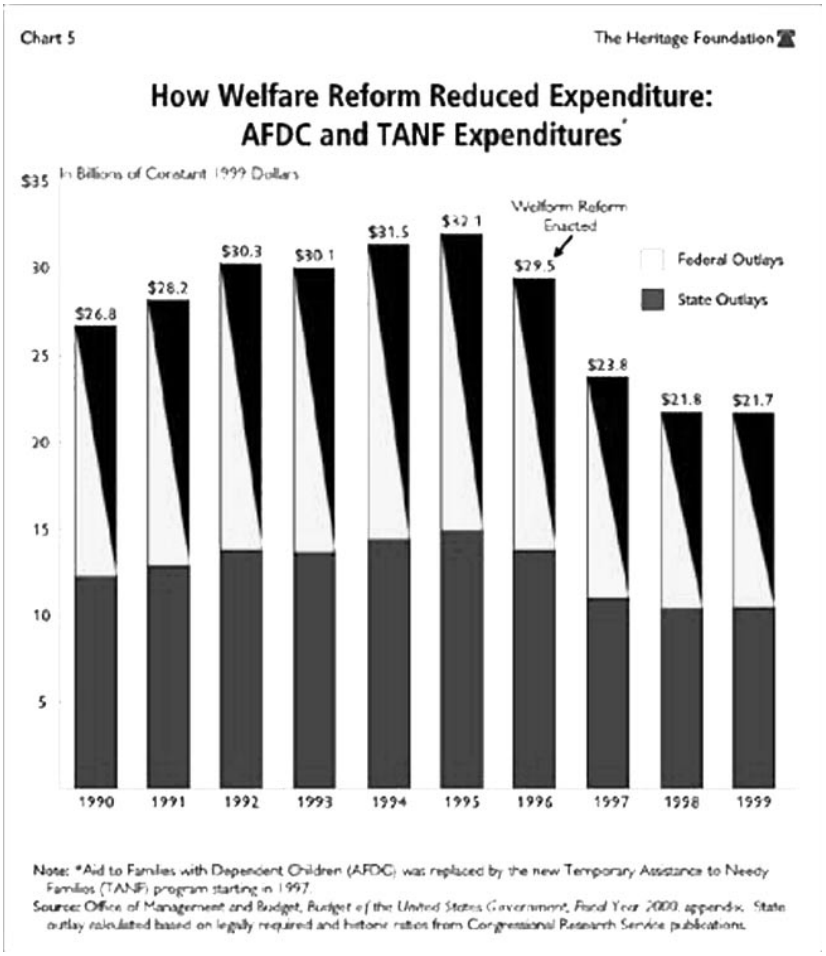
The rapid projected rate of growth of future welfare spending can be illustrated by comparing welfare to defense. The President has promised to make defense spending a priority. Under his budget plan, nominal defense outlays would increase for the first time in a half decade. Defense spending would rise by 17 percent over 5 years from $299 billion in FY2000 to $347 billion in FY2005. During the same period, however, welfare spending is scheduled to rise by 31 percent. As Chart 4 shows, the gap between welfare and defense spending will actually broaden during this period.



THE EFFECTS OF WELFARE REFORM

In 1996, Congress enacted a limited welfare reform; The Aid to Families with Dependent Children (AFDC) program was replaced by the Temporary Assistance to Needy Families (TANF) program. Critically, a certain portion of AFDC/TANF recipients were required to engage in job search, on the job training, community service work, or other constructive behaviors as a condition for receiving aid. The effects of this reform have been dramatic.

- AFDC/TANF caseloads have been cut nearly in half.
- TANF outlays have fallen substantially. (See chart 5.)
- The decline in the TANF caseload has led to a concomitant decline in Food Stamp enrollments and spending.



While critics predicted the reform would increase child poverty, the exact opposite has occurred. Once mothers were required to work or undertake constructive activities as a condition of receiving aid they left welfare rapidly. Employment of single mothers increased substantially and the child poverty rate fell sharply from 20.8 percent in 1995 to 16.3 percent in 2000. The black child poverty rate and the poverty rate for children living with single mothers are both at the lowest points in U.S. history.

In the welfare reform of 1996 all sides came out as winners: taxpayers, society and children. By requiring welfare mothers to work as a condition of receiving aid, welfare costs and dependence were reduced. Employment increased and poverty fell. Moreover, research shows that prolonged welfare dependence itself is harmful to

children; reducing welfare use and having working adults in the home to serve as role models for children will improve those children's prospects for success later in life.

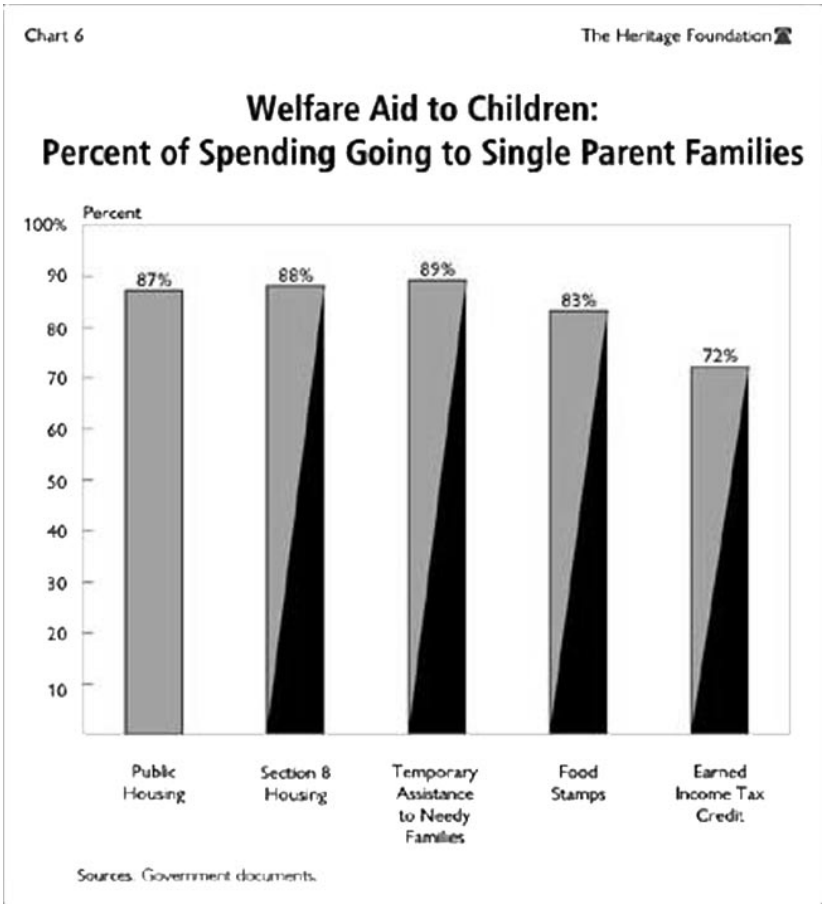
The workfare principles of the 1996 reform should be intensified and expanded. Work requirements in TANF should be strengthened. Similar work requirements should be established in the Food Stamp and public housing programs. Finally, because the reform has clearly succeeded in cutting welfare use, TANF outlays should be reduced by 10 percent in future years.

WELFARE SPENDING AND THE COLLAPSE OF MARRIAGE

As noted previously, about half of all means-tested welfare spending is devoted to families with children. Of this spending on children, nearly all goes to single parent families. Chart 6 shows the percent of aid to children in major welfare programs which flows to single parent families. The single parent share is generally well above 80 percent.

Clearly, the modern welfare state, as it relates to children is largely a support system for single parenthood. Indeed, without the collapse of marriage which began in the mid-1960's, the part of the welfare state serving children would be almost nonexistent.

The growth of single parent families, fostered by welfare, has had a devastating effect on our society. Today nearly one third of all American children are born outside marriage. That's one out-of-wedlock birth every 35 seconds. Of those born inside marriage, a great many will experience their parents' divorce before they reach age 18. Over half of children will spend all or part of their childhood in never-formed or broken families.



This collapse of marriage is the principal cause of child poverty and a host of other social ills. A child raised by a never-married mother is seven times more likely to live in poverty than a child raised by his biological parents in an intact marriage. Overall, some 80 percent of child poverty in the U.S. occurs to children from broken or never-formed families. In addition, children in these families are more likely to become involved in crime, to have emotional and behavioral problems, to be physically abused, to fail in school, to abuse drugs, and to end up on welfare as adults.

Since the collapse of marriage is the predominant cause of child-related welfare spending, it follows that it will be very difficult to shrink the future welfare state unless marriage is revitalized. Policies to reduce illegitimacy, reduce divorce and expand and strengthen marriage will prove to be by far the most effective means to:

- reduce dependence;
- cut future welfare costs;
- eradicate child poverty; and,
- improve child well-being.

Tragically, current government policy deliberately ignores or neglects marriage. For every $1,000 which government currently spends subsidizing single parents, only one dollar is spent attempting to reduce illegitimacy and strengthen marriage.

Fortunately, President's Bush's budget plan does propose a new program to "promote responsible fatherhood." This proposed program could become the seedbed for a broad array of new initiatives to strengthen marriage. Still, the money requested is pitifully small: only $64 million per year. This amounts to roughly one penny for each one hundred dollars in projected welfare spending. The budget allocation to the new fatherhood program in FY 2002 should be increased fivefold with the funds di-

verted from TANF outlays. Beyond FY 2000 some 5 to 10 percent of Federal TANF funding should be devoted to pro-marriage activities.

CONCLUSION

When Lyndon Johnson launched the War on Poverty he did not envision an endless growth of welfare spending and dependence. If Johnson returned today to see the size of the current welfare state he would be deeply shocked.

President Johnson's focus was on giving the poor a "hand up" not a "hand out." In his first speech announcing the War on Poverty, Johnson stated, "the war on poverty is not a struggle simply to support people, to make them dependent on the generosity of others." Instead, the plan was to give the poor the behavioral skills and values necessary to escape from both poverty and dependence. Johnson sought to address the "the causes, not just the consequences of poverty."

Today, President Johnson's original vision has been all but abandoned. We now have a clear expectation that the number of persons receiving welfare aid should be enlarged each year, and that the benefits they receive should be expanded. This expectation is clearly reflected in the future spending projections in Appendix A. Any failure to increase the numbers of individuals dependent on government and the benefits they get is regarded as mean spirited.

Yet the expansion of the conventional welfare system is destructive. More than twenty years ago, then President Jimmy Carter stated, "the welfare system is antiwork, antifamily, inequitable in its treatment of the poor and wasteful of the taxpayers' dollars." President Carter was correct, yet today little has changed except that the welfare system has become vastly larger and more expensive.

This expansion of welfare spending has harmed rather than helped the poor. Instead of serving as a short-term ladder to help individuals climb out of the culture of poverty, welfare has broadened and deepened the culture of self-destruction and trapped untold millions in it.

Rather than increasing conventional welfare spending year after year, we should change the foundations of the welfare system. Policy makers should embrace three basic goals.

1. We should seek to limit the future growth of aggregate means-tested welfare spending to the rate of inflation or slower.

2. We should require welfare recipients to perform community service work as a condition of receiving aid along the lines of the TANF program operating in Wisconsin.

3. We should support programs which foster and sustain marriage rather than subsidizing single parenthood. In addition, we should reduce the antimarriage penalties implicit in the welfare system.

These three goals are synergistic. They will operate in harmony and reinforce each other. In the long run, it will be difficult to control welfare spending merely by cutting funding. Rather, if we change the behaviors of potential recipients we will reduce the need for future aid. As the need for aid diminishes, spending growth will slow and then decline, and the well being of the poor and society as a whole will rise.

ENDNOTES

1. A very small number of the programs listed in Appendix B are targeted to low income communities rather than low income individuals. While such programs are not formally means-tested, they should be considered part of the overall welfare system. Only a small fraction of aggregate welfare spending is provided through such programs.

2. Appendix B provides a list of the major Federal and state welfare programs covered in this testimony.

3. The White House, A Blueprint for New Beginnings: A Responsible Budget for America's Priorities, (Washington, D.C.: U.S. Government Printing Office, 2001)

4. Income Security (function code 600) contains some nonwelfare expenditures, specifically outlays for retired Federal employees and other retirement spending. However, the rate of growth of this retirement spending changes little from 1 year to the next, therefore once the code 600 outlay totals are known one can predict the means-tested component with reasonable accuracy.

5. The White House, p. 196.

6. Projected outlay figures taken from Office of Management and Budget, Budget of the United States Government: Fiscal Year 2001, (Washington, D.C.: U.S. Government Printing Office, 2000). Table 32–2, pp. 352–364.

7. The outlay figures in Appendix A are less detailed than the past spending figures used in Table 1. This accounts for small discrepancies between the FY2000 fig-

ures in Table 1and Appendix A. These minor differences do not appreciably affect the overall analysis.

APPENDIX A: PROJECTED WELFARE SPENDING IN FUTURE YEARS

(in millions of dollars)

WELFARE OUTLAY PROJECTIONS										
PROGRAM CATEGORIES	BUDGET CODE	SPENDING TYPE	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Cash Assistance (Federal)								
Temporary Assistance to Needy Families	600	Mandatory	14,996	15,828	16,612	17,440	17,965	18,190
Supplemental Security Income	600	Mandatory	27,756	28,949	30,225	31,549	33,054	37,056
SSI Adminstration	600	Discretionary	2,359	2,590	2,592	2,619	2,682	2,741
Earned Income Tax Credit	600	Mandatory	25,676	25,799	26,876	27,683	28,701	29,722
Refugee Aid	600	Discretionary	444	446	440	436	440	447
Foster Care	500	Mandatory	5,495	6,294	6,900	7,470	8,113	8,842
Cash Sub-total			76,726	79,906	83,645	87,197	90,955	96,998
Food and Nutrition Aid (Federal)								
Food and Nutrition Assistance	600	Mandatory	29,597	31,446	31,133	34,753	36,243	37,556
Food and Nutrition Assistance	600	Discretionary	4,577	4,770	4,772	4,862	4,940	5,050
Food Aid Sub-total			34,174	36,216	35,905	39,615	41,183	42,606

APPENDIX A: PROJECTED WELFARE SPENDING IN FUTURE YEARS

(in millions of dollars)

			FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Housing and Energy Aid (Federal)								
Housing Assistance	600	Discretionary	29,176	30,631	31,172	32,094	32,841	33,339
Energy Assistance	500	Discretionary	1,242	1,105	1,102	1,110	1,133	1,159
Housing and Energy Sub-total			30,418	31,736	32,274	33,204	33,974	34,498
Cash, Food, Housing and Energy Sub-total			141,318	147,858	151,824	160,016	166,112	174,102
Medical Assistance (Federal)								
Medicaid Grants	550	Mandatory	116,117	124,838	133,968	144,900	156,610	169,763
State Children's Health Fund	550	Mandatory	1,300	1,905	2,505	3,000	3,100	3,100
Indian Health	550	Discretionary	2,346	2,593	2,619	2,633	2,695	2,748
Medicaid Buy in to Part B	570	Mandatory	11,437	12,617	13,059	14,442	15,452	16,942
Medical Assistance Sub-total			131,200	141,953	152,151	164,975	177,857	192,553
Directed Social Services (Federal)								
Social Services Block Grant	500	Mandatory	1,623	1,998	1,719	1,710	1,710	1,710
Child Care and Child Development Block Grant	600	Discretionary	1,242	1,105	1,102	1,110	1,133	1,159
Child Care Entitlement to the States	600	Mandatory	2,420	2,958	3,273	3,323	3,323	3,317
Social Services Sub-total			5,285	6,061	6,094	6,143	6,166	6,186

APPENDIX A: PROJECTED WELFARE SPENDING IN FUTURE YEARS

(in millions of dollars)

			FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Training Assistance (Federal)								
Welfare to Work Grants	500	Mandatory	960	1,370	130	13	0	0
Training and Employment Services	500	Discretionary	5,347	5,680	5,795	6,056	6,228	6,358
Training Sub-total			6,307	7,050	5,925	6,069	6,228	6,358
Targeted Education Aid (Federal)								
Education for the Disadvantaged: Title I and Related Programs	500	Discretionary	8,379	8,565	9,055	9,147	9,190	9,254
Head Start and Other Family Services	500	Discretionary	6,214	7,013	7,768	7,821	7,901	8,046
Pell Grants and Related Post-Secondary Aid for Low Income Students	500	Discretionary	9,363	9,829	10,349	10,308	10,553	10,810
Targeted Education Sub-total			23,956	25,407	27,172	27,276	27,644	28,110
Community Development Aid (Federal)								
Community Development Block Grant	450	Discretionary	4,856	4,826	4,956	4,997	5,074	4,979
Economic Development Administration	450	Discretionary	437	439	436	425	436	453
Appalachian Regional Commission	450	Discretionary	151	1,113	66	54	64	71
Community Development Sub-total			5,444	6,378	5,458	5,476	5,574	5,503

APPENDIX A: PROJECTED WELFARE SPENDING IN FUTURE YEARS

(in millions of dollars)

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Sub-Total: Federal Welfare Spending	141,318	147,858	151,824	160,016	166,112	174,102
On Cash, Food, Housing, and Energy Aid						
Total Federal Welfare Spending	313,510	334,707	348,624	369,955	389,581	412,812
On Behalf of Poor and Low Income Persons						
Estimated State Contributions to Welfare	122,269	130,536	135,963	144,283	151,937	160,997
Combined Federal and State Welfare Spending	435,779	465,243	484,588	514,238	541,517	573,808
On Behalf of Poor and Low Income Persons						

Sources: Office of Management and Budget, *Budget of the United States Government Fiscal Year 2001*, Table 32-2

Estimated state contributions based on legally required ratios of state spending as a share of federal programs and other historical data. See Vee Burke, *Cash and Non Cash Benefits for Person With Limited Income: Eligibility Rules, Recipient and Data, FY 1996-FY1998,* Congressional Research Service, Library of Congress, December 15, 1999

APPENDIX B
List of Welfare Programs

CASH AID

Cash 01)	Aid to Families with Dependent Children/ Temporary Assistance for Needy Families
Cash 02)	Supplemental Security Income (SSI)
Cash 03)	General Assistance: Cash (independent state programs with no federal component)
Cash 04)	Earned Income Tax Credit (EITC) [refundable component only]
Cash 05)	Foster Care: Title IV E
Cash 08)	Adoption Assistance
Cash 09)	General Assistance to Indians

MEDICAL AID

Medical 01)	Medicaid
Medical 02)	General Assistance: Medical Care (independent state programs)
Medical 03)	Indian Health Services
Medical 04)	Maternal and Child Health Services Block Grant, Title V of the Social Security Act
Medical 05)	Community Health Centers
Medical 06)	Medical Assistance to Refugees and Cuban/Haitian Entrants
Medical 07)	Migrant Health Centers
Medical 08)	Medicaid Buy-In to Part B Medicare

FOOD AID

Food 01)	Food Stamps
Food 02)	School Lunch Program (free and reduced price segments for children with family incomes below 185 percent of the federal poverty income threshold)
Food 03)	Special Supplemental Food Program for Women, Infants and Children (WIC)
Food 04)	The Emergency Food Assistance Program (TEFAP)
Food 05)	Nutrition Program for the Elderly
Food 06)	School Breakfast Program (free and reduced price segments for low-income children)
Food 07)	Child and Adult Care Food Program (means-tested and low-income component)
Food 08)	Summer Food Service Program for Children
Food 09)	Needy Families Food Distribution Program (commodity food distribution program on Indian reservations in lieu of food stamps)
Food 10)	Commodity Supplemental Food Program (CSEP) for Mothers, Children, and Elderly Persons
Food 11)	Special Milk Program (free segment)

HOUSING AID

Housing 01)	Section 8 Lower-Income Housing Assistance
Housing 02)	Low-Rent Public Housing
Housing 03)	Section 502 Rural Housing Loans for Low-income Families
Housing 04)	Section 236 Interest Reduction Payments
Housing 05)	Section 515 Rural Rental Housing Loans
Housing 06)	Section 521 Rural Rental Assistance Payments
Housing 07)	Section 235 Homeownership Assistance for Low-Income Families
Housing 08)	Section 101 Rent Supplements
Housing 09)	Indian Housing Improvement Grants
Housing 10)	Section 504 Rural Housing Repair Loans and Grants for Very-Low-Income Rural Homeowners
Housing 11)	Section 514 Farm Labor Housing Loans

Housing 12)	Section 523 Rural Housing Self-Help Technical Assistance Grants and Section 523 Rural Housing Loans
Housing 13)	Section 516 Farm Labor Housing Grants
Housing 14)	Section 533 Rural Housing Preservation Grants for Low-Income Rural Homeowners
Housing 15)	Public Housing Expenditures by State Governments
Housing 16)	Homeownership and Opportunity for People Everywhere (HOPE)
Housing 17)	Home Investments Partnerships Program (HOME)

ENERGY AID

Energy 01)	Low-Income Home Energy Assistance Program
Energy 02)	Weatherization Assistance

EDUCATION AID

Education 01)	Pell Grants
Education 02)	Head Start
Education 03)	Title I Grants to Local Education Authorities for Educationally Deprived Children under the Elementary and Secondary Education Act
Education 04)	Supplemental Educational Opportunity Grants (SEOG)
Education 05)	Chapter One Migrant Education Program
Education 06)	Special Programs for Students from Disadvantaged Backgrounds (TRIO programs)
Education 07)	Leveraging State Student Incentive Grants (SSIG) for Needy Students
Education 08)	Fellowships for Graduate and Professional Study for the Disadvantaged and Minorities
Education 09)	Follow Through
Education 10)	Even Start

JOBS AND TRAINING AID

Training 01)	Training for Disadvantaged Adults and Youth (JTPA II-A) Block Grant
Training 02)	Youth Opportunity Grants and Youth Training
Training 03)	Job Corps (JTPA-IV)
Training 04)	Senior Community Service Employment Program
Training 05)	Job Opportunity and Basic Skills Training (JOBS)
Training 06)	Foster Grandparents
Training 07)	Senior Companions
Training 08)	Migrant and Seasonal Farm Workers Training Program
Training 09)	Indian and Native American Employment and Training Program

SOCIAL SERVICES

Services 01)	Social Services Block Grants (Title XX)
Services 02)	Community Services Block Grant
Services 03)	Legal Services Corporation
Services 04)	Emergency Food and Shelter Program
Services 05)	Social Services for Refugees and Cuban/Haitian Entrants
Services 06)	Title X Family Planning
Services 07)	Volunteers in Service to America (VISTA)
Services 08)	Title III b Supportive Services under the Older Americans Act
Services 10)	Child Care and Development Block Grant
Services 11)	Child Care Entitlement to the States

DEVELOPMENT AID

Community Aid 01)	Community Development Block Grant
Community Aid 02)	Urban Development Action Grant Program (UDAG)
Community Aid 03)	Economic Development Administration
Community Aid 04)	Appalachian Regional Development Program

Chairman NUSSLE. Thank you.

For the members' benefit, we have three votes that are scheduled on the floor. I am going to ask Mr. Primus to go ahead and give us his testimony, I would like to hear it, and then we will go and vote. We will come back after the votes to ask questions of the witnesses.

STATEMENT OF WENDELL PRIMUS, DIRECTOR, INCOME SECURITY, CENTER ON BUDGET AND POLICY PRIORITIES

Mr. PRIMUS. Thank you for the opportunity to testify today.

I would like to review what we know about the implementation of welfare reform and then talk a little about the Bush budget.

Welfare reform has coincided with the longest running economic expansion in our Nation's history. Unemployment has fallen from 6.9 to 4 percent and hourly wages for the very bottom of the wage distribution is increasing in real terms. We have also had enacted make work pay policies of increasing the earned income tax credit and significant increases in child care expenditures. Those policies and that very strong economy have produced some very positive outcomes, more positive than I would have predicted in 1996.

We clearly see that single mothers are working more, earning more. In fact, the poorest 40 percent of mothers are earning about $2,300 more each below about 115 to 120 percent of poverty. As a result, child poverty has decreased. Under a measure of child poverty that includes food stamps, housing and the earned income tax credit, it is now 12.9 percent, the lowest level since this measure began in 1979. Caseloads have declined 56 percent in TANF, 35 percent in food stamps since 1994.

That is the very positive news. I want to emphasize is it has come because of welfare reform, the strong economy and the make work pay policies. We are really not able to disentangle which is responsible for what parts of that very good news.

There is also some very troubling news. After adjusting for inflation, the very poorest mothers, those below 75 percent of poverty, fell 4 percent between 1995 and 1999. We think about 700,000 families in this very strong economy have actually lost ground. The poverty gap really has not budgeted much. If you look at the table in my testimony, I show that if you do not count any government and looks at earnings, it decreased significantly from 1993 to 1995 to 1999.

After you count all government taxes and transfers, there was almost no progress made between 1995 and 1999. In fact, this low income mother on average who earned $2,300 more has only gotten an increase in income of about $300 despite that increased earnings.

Many of those working families lost food stamps and President Bush was appropriately concerned about the very high, marginal tax rates as families entered the income tax system. However, single mothers with incomes between $13,000 and $20,000 typically face marginal tax rates well above 50 percent.

What does that mean? That means if they go out and earn an additional $1,000, they get to keep less than $500 of that. That is because there is a food stamp tax rate of about 30 percent, that varies between 24 and 36 percent. There is the EITC phase-out of 21 percent. They pay employee taxes and they also pay child care co-pays in many cases as well as health insurance co-pays.

In your State of Iowa, we did some calculations, Mr. Chairman, that looked at a mother say that had an increase in earnings from $14,000 to $20,000. She gets to keep 30 percent of that $6,000 increase in earnings. So we think that the Bush administration has missed many opportunities.

I want to add that while we have made enormous progress with single mothers, we have not done nearly as well for young black men in terms of increasing their labor forced participation and the

MDRC tells us that we need both income and earnings gains to really get positive outcomes.

I would characterize the Bush budget where we have a $2.5 trillion non-Social Security, non-Medicare surplus, we really could make significant improvements building upon welfare reform and reducing those marginal tax rates for the working poor.

There is no expansion of the earned income tax credit. Working families do not benefit from the Bush tax plan. We estimate that 33 percent of all children do not benefit; 55 percent of black children; 56 percent of Hispanic children do not benefit from the Bush tax plan.

We could have made the child tax credit partially refundable, say 5 to 15 percent of earnings. That would have reduced those marginal tax rates and provided a significant increase in those mothers who have responded to welfare reform and have entered the labor force.

There is no funding for the change in child support distribution rolls. I think we had a conversation last year where we know that young men who pay child support sometimes face a 100 percent tax rate. It is a mandatory payment that they should and must pay but all of the proceeds go to government because we reduce that TANF check dollar for dollar. There are no funds to improve those child support distribution rolls and fund the bill that passed the House last year, 405.

There is no expansion of Medicaid or SCHP. The typical state is a mother loses Medicaid eligibility when she hits 67 percent of poverty. There is no improvement in the safety net for the working poor legal immigrants. I also think we should have some funds to restore some of the food stamp cuts enacted in 1996 that were primarily budget cuts. It was a reconciliation bill. That would again ease some of those marginal tax rates.

In sharp contrast, the Bush budget allocates $555 trillion to the wealthiest 1 percent in this country who have incomes on average of about $800,000 and who have gained, despite their high marginal tax rates, somewhat higher, an increase in income of 50 percent. They also got a significant tax reduction in 1997. I just want to contrast what we have done for the very top versus how we could have built upon welfare reform and helped working poor families.

In terms of the actual cuts in the Bush budget, there is no extension of TANF supplemental grants which means 17 States will actually get a reduction this year unless you extend those grants. I think there is also a reduction in TANF funding because the Bush administration says we are going to add a new purpose. We are going to encourage States to encourage charitable giving. That takes $400 million away from States to aid low income families and I think primarily will reimburse middle class families for behavior they are already undertaking. We have not yet seen all of the details.

We think there is about a $2 billion cut in HUD funding. We know from the functional totals because there is an increase in education in Function 500 that there has to be a significant increase in job training monies and there is also no expansion of CHIP funds.

If you recall, States are going to get $1.1 billion less this year compared to 2001 because when it was enacted, there was this fall off in funding. Now, with the surplus, I think there is clearly a need to not go through that funding reduction.

In terms of how this fares in the State of Iowa, a State picked at random.

Chairman NUSSLE. Could I ask you to save that because I would like to hear this but I need to go and do my duty on the floor quickly and we will come back. Could we do that?

Mr. PRIMUS. Sure.

Chairman NUSSLE. The committee will be in recess until we are done with the votes.

[Recess.]

Chairman NUSSLE. Mr. Primus, I interrupted your testimony so that we could vote. I apologize for that. Please pick up where you left off. I think you were about to tell me a bit about Iowa.

Mr. PRIMUS. Thank you.

I would like to demonstrate what some of these missed opportunities mean for working poor families in Iowa.

Some 28 percent of the children in Iowa would not benefit from the Bush tax plan and 86 percent of those families include a worker. As I mentioned, I did a calculation for a single mother with two children whose earnings increased from $14,000 to $20,000. She faces a 70 percent marginal tax rate. I would argue that you ought to be about the business of trying to reduce that tax rate so that when she has entered the labor force, she gets to keep more of her earnings.

About 9 percent of the children in Iowa lack health insurance. A single mother who leaves welfare loses Medicaid assistance in Iowa when her earnings get to 90 percent of poverty. In the typical State, it is 67 percent of poverty and in most cases, when a noncustodial parent pays child support in Iowa, they essentially face an effective 100 percent tax rate.

There is one other aspect. Nancy Johnson held a hearing last year on what was an agreement among business and labor and administrators of the unemployment insurance system. The State of Iowa has to impose an employer surtax to fund its employment service. I think the budget should assume some unemployment insurance improvements along the lines of that stakeholder agreement.

Finally, I would hope that in this budget, and as the Congress thinks about reauthorizing TANF, food stamps and child care next year, one is that you make sure you reserve enough monies in the budget so that reauthorization can take place. I would hope that the authorizing committees could change the central focus from caseload reduction to poverty reduction; that we need additional supports to help the families remaining on welfare get into the work force.

Something that I have worked a lot on in the last several years is to really help noncustodial parents build capacity to support their children financially and emotionally. The Bush budget does include some new monies to really start to do that.

I think we also need to provide support to two parent families. Two parent families are not being served by our welfare system.

They have much lower participation rates in Medicaid, food stamps and TANF. I think we need to increase funding.

In terms of the budget implications, I think there is a strong case for extending the TANF supplemental grants. Those 17 States are actually going to get a decrease. In terms of funding levels, they get an average of about $700 per poor child. The nonsupplemental States get $1,700 per poor child. The States getting these extra grants have higher child poverty rates, lower fiscal capacity. The Bush budget was correct in recommending a $200 million increase a year in child welfare but they did not include the child support distribution reforms.

In conclusion, the bottom line is, I think this surplus gives you the opportunity to really build upon welfare reform and improve our work-based safety net substantially. I would urge that you reallocate some of that $555 billion you are giving to the top 1 percent in the form of a tax cut and improve in some way child care funding, Medicaid, health insurance for the working poor in this country.

Thank you.

[The prepared presentation of Wendell Primus follows:]

PREPARED PRESENTATION OF WENDELL PRIMUS, DIRECTOR OF INCOME SECURITY, CENTER ON BUDGET AND POLICY PRIORITIES

ECONOMIC CONTEXT OF WELFARE REFORM

Key Factors in Explaining the Positive Outcomes

- Welfare reform coincided with the longest-running economic expansion in our nation's history.
- Average annual unemployment fell from 6.9 percent in 1993 to 4.0 percent in 2000.
- Hourly wage rates for the lowest-paid workers began to rise after falling for two consecutive decades.
- EITC expansions to make work pay.
- Increases in child care expenditures.

POSITIVE OUTCOMES OF WELFARE REFORM

- Single mother are working more.
- In 1992, about one-third of single mothers with young children were employed; by 1999, more than half were employed.
- Single mothers are earning more.
- The poorest 40 percent of single mother families increased their earnings by about $2,300 per family on average between 1995 and 1999 after adjusting for inflation.
- Child poverty has decreased.
- Under a measure of poverty that includes government benefits and taxes, the child poverty rate fell to 12.9 percent in 1999 the lowest level since this measure became available in 1979.
- Caseloads have declined by 56 percent in TANF and 35 percent in Food Stamps since 1994.

TROUBLING RESULTS OF WELFARE REFORM

- After adjusting for inflation, the average disposable incomes of the poorest fifth of single mothers fell 4 percent between 1995 and 1999, despite increased earnings.
- According to the Current Population Survey, there are 700,000 families that have significantly less income in 1999 than their counterparts in 1995.
- The "poverty gap" has not budged significantly in recent years despite the decrease in the poverty rate.
- The poverty gap measures the total number of dollars that would be required to bring all people with incomes below the poverty line up to the poverty line.
- Trends in disposable income.

• While the poorest 40 percent of single mother families increased their earnings by about $2,300 per family on average between 1995 and 1999, their disposable income increased only $292. (All figures adjusted for inflation.)
• Many working families are inappropriately losing ancillary benefits for which they remain eligible, such as food stamps.
• Single mothers with incomes between about $13,000 and $20,000 face very high marginal tax rates.
• The labor force participation rates of young African American men has fallen 6 percentage points between 1993 and 1999.
• MDRC results show that positive outcomes for children require both work and income gains.

BUILDING ON WELFARE REFORM

Missed Opportunities to Help the Working Poor

• No expansions of the Earned Income Tax Credit, such as:
• A "third tier" in the EITC for families with three or more children.
• Reduction in the marriage penalty in the EITC.
• Expansion of the EITC in targeted income ranges to reduce marginal tax rates.
• Working poor families do not benefit from the Bush tax plan.
• Some 33 percent of all children will not benefit from the Bush tax plan; 55 percent of Black children and 56 percent of Hispanic children will not benefit.
• Could make the child tax credit partially refundable, by refunding a small percentage of earnings (between 5 percent and 15 percent) up to a maximum credit of $1,000 per child.
• No funds to improve child support distribution rules like H.R. 4678, which passed the House 405–18.
• Many low-income noncustodial parents face an effective tax rate of 100 percent when they pay child support.

Missed Opportunities to Help the Working Poor

• No expansion of Medicaid or SCHIP for working parents and the many children who remain uninsured.
• In the median state, a parent in a family of three loses Medicaid eligibility when her income surpasses 67 percent of the poverty line.
• No improvement in the safety net for legal immigrants.
• Should restore food stamp benefits for the working poor and states should have the option to restore Medicaid coverage.
• No funds to improve the Food Stamp program and restore "budget" cuts enacted in 1996 that affected working families, among others.
• In sharp contrast, the administration budget allocates $555 billion to benefit the richest 1 percent of Americans over the next decade, a group whose real income increased nearly 50 percent since 1989 and who enjoyed a significant tax cut in 1997. This amount is more than health, education, and all other initiatives combined.

CUTS IN LOW-INCOME PROGRAMS

• No extension of TANF supplemental grants.
• Currently, wealthier states receive about $1,778 in TANF dollars per poor child, while poorer states that received supplemental grants receive $733 per poor child.
• Reduction in TANF funding for low-income families because $400 million spent on state tax credits for charitable giving.
• $2.2 billion cut in real funding for HUD programs.
• Reductions in job training monies.
• There is no expansion of SCHIP funding to offset a cut of $1.125 billion in FY 2002 compared to FY2001. This cut was a budget-related measure included when the program was enacted.

THE WORKING POOR IN IOWA

• Some 28 percent of children in Iowa will not benefit from the Bush tax plan; 86 percent of excluded families include a worker.
• Single mothers with two children and child care expenses face average marginal tax rates of 70 percent as their earnings increase from $14,000 to $20,000.
• Some 9 percent of children in Iowa lack health insurance coverage.
• A single mother leaving welfare loses health insurance coverage when her income reaches 90 percent of the poverty line.
• In many cases, low-income NCPs face an effective 100 percent tax rate on the child support they pay.

• Because of employment service funding reductions, Iowa has been forced to enact a special surcharge on employers. The budget should assume unemployment insurance improvements.

BUILDING ON WELFARE REFORM: TANF REAUTHORIZATION

• Change the law's central focus from caseload reduction to poverty reduction.
• Support families in the transition from welfare to work by providing appropriate services for adults with significant employment barriers, examining sanction policies, and modifying the time limit on Federal cash assistance.
• Help noncustodial parents build capacity to support their children both financially and emotionally.
• Provide services to strengthen two-parent families and help fragile families stay together.
• Increase funding and make states more accountable for how they use their TANF block grant funds.
• The block grant should be indexed for inflation.
• Additional funds to reduce the vast disparities in resources available to poorer states.
• A more effective measure is necessary to provide states additional funds in case of an economic downturn.

BUDGET IMPLICATIONS

• Extend TANF Supplemental Grants and put in baseline.
• Child Welfare.
• Child Support distribution reform.
• Fatherhood/Employment services for low-income NCPs.
• Unemployment Insurance reform.
• Monies for TANF, child care, the Social Services Block Grant, Food Stamps, Medicaid, and SCHIP.

Chairman NUSSLE. Thank you both for your testimony with regard to welfare reform and poverty.

There is no question that the percentage both of you used, 56 percent of a reduction in the welfare rolls, that to a very large extent the reforms we put into place in 1996 have been generally very successful, that there are a lot of success stories. I think what both of you are telling us is that there are challenges that lie ahead and you are giving us some advice on how best to meet those challenges.

Apart from the argument you make about the $555 billion going to the top 1 percent, which my information tells me some of that tax cut is attributed to people who are deceased which is an interesting way of computing it but probably not very realistic.

Aside from that, a debate over tax cuts, I think there is a longer term issue here that both of you discuss and that is how do we meet this challenge? What do we do? Obviously there are some good reforms that were put into place creatively both by the Federal Government and by the State Government. There are still people both in Iowa, as well as every State, who have not yet been able to figure out the benefit, or we have not figured out how to benefit and get them on their feet. It is not just a matter of providing the assistance; it is also a matter of moving them from dependency to independence.

The question I would have is, what are your specific recommendations? I understand what you are saying about the tax cut. Suggest for a moment, you have lost that argument, what other suggestions would you make with regard to specific proposals and reforms that you would hope to see us consider as part of our moving forward, whether in this budget or budgets in years to come?

Mr. RECTOR. I would offer a number of points. The first is that I think if you listen to Mr. Primus, and I have listened to him for 20 years now, you would think the welfare system was cut and cut and cut and cut, but somehow when you look at the chart, it keeps going up and the taxpayers keep paying more.

Since 1965, welfare spending, even after adjusting for inflation, has increased every year but four. Every year it goes up. Somehow, the book of Proverbs tells us, "The eyes of man are never full." No matter what is spent here, we have doubled spending in the last 10 years. You can always come back and hear dozens and dozens of recommendations of why to spend more. Somehow the situation never seems to improve. I think that is basically because we are spending on the wrong things.

If we spend on one-way handouts, if we spend on programs that reward idleness and reward single parenthood, you get more idleness and more single parenthood. That is the one thing we have learned from welfare reform.

I would recommend a number of fundamental things. One is I think you need to set a reasonable goal for future spending. I think cash, food and housing should increase no faster than the rate of inflation in future years. The underlying philosophy behind that is as Lyndon Johnson said, "We want to have fewer people on welfare, not more." We should have fewer people. Simply let the spending increase no faster than the rate of inflation would allow for some increases while having a declining population on the rolls.

The second, most important thing I think we could do in terms of welfare program structure is to recognize that the reform we passed in 1996 was only a half of a reform. The most significant thing that happened in 1996 was we passed national requirements that said women on AFDC are required to undertake some community work service or job search or some sort of constructive activity as a condition for getting aid. When we did that, the caseload dropped in half; the employment rates went up; the child poverty rate for black children and children in single parent families is now at the lowest point in the entire history of the United States largely as a result of that Act. That Act is quite weak. Most people do not realize that of the 2 million welfare mothers still left on the rolls, half are sitting there idly at home, not doing anything.

One thing we should do as we look toward TANF reauthorization is have a requirement that all parents on TANF be required on a weekly basis to participate in some sort of constructive activity leading to self-sufficiency.

The other thing we need to understand is if we look at public housing, of the aid that goes to children, 80 to 90 percent is to single parents; Section 8 housing, same thing; earned income tax credit, something like 66 percent; food stamps, aid to children, some 80 percent goes to single parents. These programs exist largely as subsidy systems that are trying to address the collapse of marriage that began in the 1960's. None of this spending would occur if that collapse of marriage had not occurred.

Child poverty, 80 percent of the child poverty in the United States today occurs to children from either a home where the mother never married or some sort of home that is broken or fractured. Child poverty and welfare and single parenthood are essentially all

the same problem, yet we never address why welfare exists. We never address why that poverty exists.

The first and foremost thing I would recommend in future years is we need to begin to devise active programs to encourage marriage rather than penalize it and recognize that all of these welfare programs as means tested programs implicitly penalize marriage. If the woman has a boyfriend who is the father of the child but he has earnings, she gets to keep most of her welfare income as long as she is not married to him. The moment she marries him, his earnings are counted against her welfare eligibility and those benefits are going to be substantially reduced.

The whole system is antimarriage and has been that way for a long time and it is also agnostic. It never talks to parents about the value of marriage. Eighty-five percent of all the out-of-wedlock child births are paid for right at the front door by Medicaid. That is the first payment you have for that child, a substantial one.

In close to half of those cases, most of these are women in their early 20's, in close to half of those the woman is actually cohabiting with the father at the time of birth, he is right there in the home, they have a reasonable relationship. In no State in the United States does the Government even say, have you two thought about getting married, can we tell you what the effects on this child would be if you did get married. Could we tell you the effects on one another? Could we provide you with some mentoring services or some skills to try to improve your relationships? That is the singlemost important thing you could do to improve the well being of that child, reduce his future prospect for child poverty as well as substantially welfare outlays in the United States.

You could go from California to Maine and not find a single brochure in any Government office that says anything positive to that young couple about marriage. I regard that as a terrible tragedy.

The last concrete recommendation I would make is that I think TANF has been very successful in reducing dependency and poverty and it is time that the taxpayer gets some reward for that success. Therefore, I would recommend that when TANF is reauthorized next year, the future budget authority for TANF should be fixed and cut by 10 percent above existing levels. That still leaves more than enough funding to keep the TANF reform going forward, particularly if you improve the work requirements.

Chairman NUSSLE. Mr. Primus.

Mr. PRIMUS. I will try to be brief.

I strongly support work and I think you have to encourage work is by reducing those marginal tax rates I talked about. In the case of Iowa, it might be providing more child care dollars so they do not have to impose a co-pay but it also could be by reducing the phaseout in the earned income tax credit. Today, we take away 21 cents for every dollar that is earned. Perhaps we should only take away 10 or 15 cents until the family has lost food stamp eligibility.

Another way we could reduce marginal tax rates is making the child tax credit refundable against earnings. In other words, phase it in say at a 10 percent rate, so your mother and two kids reach the $1,000 at $20,000, $1,000 for each child. That would also reduce marginal tax rates.

I think welfare reform has worked better than I thought. Those mothers are working more but they are keeping as much of their income.

The other thing I think is Medicaid. Today working parents lose Medicaid in the typical State at 67 percent of poverty. I think you have to provide additional SCHP or Medicaid funds so States can cover the working poor to a higher level. Those three things would do a lot for the work base.

Let me say something about marriage. I think there is a limit to what Government can do. It cannot make two people love each forever, even if they produced a child. There is research that suggests that the Child Support Enforcement Program, the stronger it is, it reduces out of wedlock births and it lowers divorce rates, not a heck of a lot but statistically significant.

I think we should be moving toward a universal child support system where the cultural is if you do not live with your kids, you pay. For some of the dads at the very bottom of the earning spectrum, we also need to help them get into the labor force and we need to reduce the 100 percent tax rate on child support at the bottom. That is one very concrete thing you could do.

Chairman NUSSLE. I appreciate your recommendations.

Are there other members who wish to inquire? Ms. Clayton.

Ms. CLAYTON. I do have a statement and a couple of questions.

Mr. Rector, many of the points you make I certainly agree with. However, I have an overriding feeling that you have made poor people a scapegoat by the fact that increased government spending has occurred and there are still more people who are dependent on less food. I could take a chart for the same period of time and look at defense spending and see it go up. I do not think it goes up in proportion.

I can also tell you that I can take a budgetary projection for a number of the sectors of this Government and see it go up. I also believe that single parents add to the poverty rate and contribute to a lot of the problems. I have committed myself to teenage pregnancy long before I came to Congress. I did not have to be a Member of Congress to be engaged in that. I do that in my own community.

Again, it should not be perceived that because they are there, we do not make a difference. We turn our backs on that. Spending will go up regardless. We will either be paying more in prisons or paying more to a system. There is no way not to have society pay for dysfunctionality. So if we are not committed to changing that dysfunctionality, those issues with education, prevention of teen pregnancy and other things will continue. That is my sermon for today.

My question is, in the EITC earning, would you be in favor of increasing that for married families. Also, to what extent do you think that would help in the poverty of married families since there are married families in poverty just like singles.

Mr. RECTOR. One of the few increases in means tested spending that I would support would be an increase in the earned income tax credit for married couples. I think that would be very valuable in terms of offsetting the antimarriage effects that exist in all of these other programs. Let me emphasize again all means tested

programs inherently have a household splitting effect. A lot of people think welfare is antimarriage because married couples cannot get it. That is not true. What it says is you get welfare if you have very low earnings in your home. What is the easiest way to have very low earnings in the home is not to have an employed husband on the record. He might be a boyfriend around the block but if you get married, he is going to go on the record and you lose most of your welfare eligibility. That has been the core of antimarriage and that applies to public housing, food stamps, Medicaid and TANF.

I think making the EITC a little more marriage friendly would be an excellent way to offset that a bit, but I also think we have to get in there and give the message. I think young people today do not understand any connection between being married and having children. They actually will say stuff like that and that is a tragic thing.

I would love to go into high schools and at risk communities and talk to young women and say to them, all the data shows you want to bring a child into the world and you will in a few years but the very best thing you can do——

Ms. CLAYTON. My time is almost up. You would give that to not only poor people but to anybody, the education?

Mr. RECTOR. Yes. I think it should be targeted but I think everybody could use it.

Ms. CLAYTON. You understand divorce is increasing for those not in poverty as well?

Mr. RECTOR. Absolutely.

Ms. CLAYTON. I just want the morality standard to be for all of us, those who are poor and those who are not.

Mr. Primus, do you know of research that shows there is an impact on the economic security and families and marriage? Tell me about the economic security of marriage on families?

Mr. PRIMUS. There was a study on the Minnesota Family Investment Program by the Manpower Development Research Corporation in New York. They found there are positive outcomes for children if earnings increase and income increases. Minnesota had a very generous earnings disregard so that when you worked, you got to keep a large part of those earnings.

That same research also shows that marriage rates increased in those situations. I think the key to some of this marriage argument is making sure that males have a job. Women are not going to marry unemployed men that have very poor labor markets. I think William Wilson's research shows that, so if we really want to make sure we increase marriage and increase two-parent families, I think economic security is the first thing and that is kind of a flip side.

Mr. Rector is urging more social services. I think we should focus on an economic security plan. I also think we need to serve two parent families much better in our welfare system. There is a culture that says, welfare does not help two parent families.

Ms. CLAYTON. Mr. Rector, would you support dividing support to married couples under the TANF Program rather than just to the mother?

Mr. RECTOR. They are already supported under the TANF Program. The problem with that is that we started that in the 1980's

and it did not have much pro-marriage effect because it used to be called the AFDC Unemployed Parent Program. Two parent families could get in under the program but the condition of aid is that the father is not working. That is not what we want.

If you bring in a family and keep them on AFDC for many, many months where the dad is not working, the message you are probably sending is the dad is not really that necessary to the home. Actually, there is some research that indicates that increased family breakup.

The group we want to support and encourage is marriage of mothers to employed fathers which is why the EITC is a much better way of doing it because there the dad is working. Now you have all the elements in place. The dad is working, the mother is getting married to him, the child has two parents in the home.

In addition to providing that economic support, we need to provide counseling. We can teach people how to keep their relationships together, how not to fight and fall apart. We can do those things and that is the singlemost important thing we can do for American children.

Ms. CLAYTON. Thank you, Mr. Chairman.

Chairman NUSSLE. Ms. McCarthy.

Ms. MCCARTHY. Mr. Rector mentioned $313 billion in spending on welfare programs. I am curious if you know how much of that is actually spent on families with children? Going through the budget, I noticed that there is going to be a $1 billion cut in housing and 40 percent of those in public housing are elderly and disabled and here we are cutting.

Mr. PRIMUS. I think if you look at Mr. Rector's chart, Table 1, over half of the total amount of spending here is on Medicaid and a lot of Medicaid goes to nursing homes for the elderly. I did a calculation where I looked at all the families with children below poverty, with earnings below poverty, and I added all the means tested cash, their food stamps, their EITC, everything but health, and that totaled $40 billion. That is not the picture you are getting here. That is about $2,500 per poor child. We give a middle income child about $1,000 through the child tax credit and the personal exemption.

In fact, that $2,500 per poor child is probably less than the disparity in education funding between inner city children and suburban children in many of our communities. All of the EITC is spent on families with earnings. I do not call that welfare; I call that primarily an earnings supplement and a reduction of payroll taxes.

Ms. MCCARTHY. I still think we have a long way to go on training to get good jobs, not jobs paying $3.25 to $4.00 a hour because no one is ever going to get off welfare under those scenarios.

Chairman NUSSLE. Thank you very much.

I want to thank the panel for their insight, comments and suggestions. It is always an interesting subject and I appreciate your continued advice to us on the topic. I look forward to another opportunity sometime down the road.

Thank you.

We will introduce this next panel quickly, and then we will invite them to testify.

First is Dr. Thomas Saving, who is from the Private Enterprise Research Center at Texas A&M. Dr. Saving was appointed by the President to the Board of Trustees of Social Security and Medicare Funds, just here recently in the year 2000.

Next is Marilyn Moon. Dr. Moon is an economist with interests in health, income, security, and public policy. She is a Senior Fellow at the Urban Institute. We welcome her to the witness table. Dr. Moon has served as the Senior Analyst to the Congressional Budget Office, and she's the first Director of the Policy Institute of the American Association for Retired Persons.

Last and certainly not least is Dr. Gail Wilensky. Dr. Wilensky has done a number of things that this Congress is familiar with. She is a former Presidential appointee, as the Director and Administrator of the Health Care Finance Administration.

We heard earlier today that maybe the new Secretary of HHS may want to change that name. He said he was not sure what a HCFA was. He was not sure anyone knew what a HCFA was. So maybe you have some insight on that.

But your duties were as former Administrator, as well as Deputy Assistant for the President for Policy Development, where you advised previous President George Bush on the health care and welfare issues. You earned a BA in psychology and a PhD in economics from the University of Michigan.

We welcome all three of you. We would inform you that your full testimony will be made part of the record, and we invite you to summarize your testimony before us today.

We will start with Dr. Wilensky. Welcome.

STATEMENT OF GAIL WILENSKY, JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE

Dr. WILENSKY. Thank you, Mr. Chairman and members of the committee.

As you have indicated, I am a former HCFA administrator. I will be glad and heartily support the notion of finding a new name for the organization. I am currently the Chair of the Medicare Payment Advisory Commission.

I want it to be clear that I am not acting in either of those capacities today, but rather am providing my own views as a health policy person and an economist.

I am going to primarily talk about the administration's programs for Medicare and prescription drug coverage, the need for reform, and the extent to which the administration addresses these needed reforms. Then I will just briefly touch, if there is time, on the proposals for Medicaid reform, and also proposals for the uninsured.

The administration has proposed spending $153 billion over the 10 year period, fiscal 2002 to 2011, to modernize and reform Medicare. The specifics of what the administration is going to propose in terms of long-term reform are not yet clear. There is some funding for a temporary program to provide assistance to low income seniors and seniors with catastrophic expenses.

There is no question that the program needs to be reformed. Reforming the regulatory structure is commonplace discussion in Washington now and outside. People understand that the benefits are inadequate. There is some very questionable solvency issues,

particularly when you think about Part B, and not just the Part A trust fund, and it is a very administratively complex program.

In my opinion, as important as the inadequate benefits are, not having out-patient prescription drug coverage and catastrophic coverage, it would not be a good idea to do a standalone drug benefit, outside of the context of further reform of the Medicare Program

The reason is, I believe that it is imprudent to substantially increase the spending needs of a program that is already in a financially fragile state, without doing something to reform the program.

Second of all, if history is any guide, however much you think the program will cost, you will be wrong. If we look at the ESRD experience, we are seeing a six or seven billion dollar program, after anticipating a much smaller program.

Between the time the catastrophic legislation that was passed in 1988 and repealed in 1989, the prescription portion of that bill increased by a factor of two-and-a-half fold from the time it was first proposed until the time it was actually repealed. We do not know what it would have actually cost. We never got that far.

So it seems pretty likely that we will undershoot that estimate. As you know, CBO has recently put out new estimates about how much faster drug spending has gone up for the elderly than we had thought.

Finally, the design issues of a drug benefit program are difficult and have not yet been determined. It would be very useful if the Congress could decide how it wanted to reform Medicare and start now.

The fact is, building a infrastructure for a reformed Medicare will take time. Future seniors need to know the program that they will face.

Future seniors will be very different from the people whw are now on the Medicare Program. They will be better educated, and they will frequently have more income. Many of the woman will have worked full time, or at least substantially during the entire adult period, and their experiences with the work force and their health plans will be very different.

The question, or at least one question you will need to consider, is whether a temporary program for those most in need is a reasonable interim step.

It might be, as the administration has proposed, as a block grant to try to make use of the fact that 26 states have some kind of assistance programs; or it might be a program that starts first with the special populations under Medicare, the so-called QIMBY and SLIMBY populations; the qualified Medicare beneficiary in the selected low income populations, that get special help paying their deductibles and co-insurance and premiums. They are not on Medicaid, but they get special help.

In order to do that, you would have to make a lot of the decisions about designs. In order to do the block grant, you would have to go through new legislation and possibly run the risk of having money out there, which would be hard to curtail.

So whether or not we have a temporary program, although you can make good arguments as to why we should help now those most in need while we get ready for long term reform, whether it

is really worth the political capital is something you will have to decide.

What I would caution is be wary if you do not do Medicare reform and prescription drug coverage; be wary about spending more to increase payments to providers.

I think there is some justification that could be made for the two previous pieces of legislation following the Balanced Budget act, the so-called BBRA, and the Beneficiary Improvement and Protection Act, that was signed into law last December.

But it appears, at least for hospitals, that providers are doing much better financially. It appears based on three-quarters data that is now available for 2000, that margins are back up around the rate they were in 1997.

So if we do not see agreement on Medicare reform, I caution you to be careful about spending that money that is set aside for increasing provider payments.

I have two quick words on the other areas in the administration proposal. One is about Medicaid. The specific legislative proposals about Medicaid have not yet been released, but there was included in the budget a substantial savings, $17.5 billion roughly, from Medicaid that involved tightening up the upper payment limit provisions for which there was some improvement in December when HCFA issued some new regulations.

This is once again an area in which the states have shown themselves to be very creative at finding ways to increase the Federal share of match in Medicaid; having been at HCFA during voluntary donations and provider taxes, the first wave of creative financing, now to be replaced with upper payment limit in intergovernmental revenues.

It is not clear to me that we can continue to rely on the matching grant, where the states put in part of the money as an effective cost containment mechanism for Medicaid.

It may be time to think about other strategies that would convert the structure of the program and still allow for state flexibility, which is clearly of interest, both to the Secretary and to the President, as well to the Governors. I would be glad to talk about what that might look like, if there is time later.

Finally, I want to recognize although the details are not yet very clear, the administration will be proposing a multi-prong strategy for the uninsured: a refundable tax credit, combined with efforts to build the infrastructure by increasing substantially the amount of money for community health centers, and by providing some funds to innovative local organizations.

It recognizes that if we are going to make inroads in trying to reduce the numbers of uninsured, it will take a series of steps and strategies.

Thank you very much, Mr. Chairman.

[The prepared statement of Gail Wilensky follows.]

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D., JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE

Mr. Chairman and members of the Budget Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am the John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I chair the Medicare Payment Advisory Commission. I am also a former Administrator of the

Health Care Financing Administration. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences running HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or MedPAC.

My testimony today primarily discusses the administration's programs for Medicare and prescription drug coverage, the need for reform and the extent to which the administration addresses these needed reforms. My testimony also briefly discusses the administration's proposals for Medicaid reform and the proposals for the uninsured.

THE ADMINISTRATION'S MEDICARE PROPOSALS

The administration has proposed a program to modernize and reform Medicare that spends $64.2 billion in fiscal years 2002–2006 and $153 billion in fiscal years 2002–2011. This is in addition to $2.5 billion set aside for FY 2001 that is not included in the five or 10 year numbers.

The long-term reform plan has not yet been submitted, but the administration's principles for reform include preserving Medicare's current guarantee of access, a choice of health plans that includes the option of purchasing prescription drug coverage, covering the expenses for low-income seniors, streamlining access to new medical technologies, establishing an accurate measure of Medicare solvency and not increasing payroll taxes.

The administration is proposing an interim and temporary program that provides assistance to low-income seniors and seniors with catastrophic drug expenditures until Medicare reform is enacted and implemented. The program, Immediate Helping Hand, provides funds to the states that would cover the costs of prescription drug coverage for seniors below 135% of the poverty line with no premium and nominal co-payments. Seniors between 135% and 175% of the poverty line would receive partial coverage. Catastrophic coverage would be provided for seniors with out-of-pocket drug costs exceeding $6000 per year.

THE NEED TO REFORM MEDICARE

Although Medicare has resolved the primary problem it was created to address, ensuring that seniors had access to high quality, affordable medical care, there are a variety of problems with Medicare as it is currently constructed. The administration has correctly assessed the most important of these flaws: inadequate benefits, financial solvency, excessive administrative complexity and an inflexible Medicare bureaucracy.

A part of the motivation for Medicare reform clearly has been financial, particularly concern about the solvency of the Part A Trust Fund. Part A funds the costs of inpatient hospital care, Medicare's coverage of skilled nursing homes and the first 100 days of home care. The Part A Trust Fund is primarily funded by payroll taxes. The changing demographics, associated with the retirement of 78 million babyboomers between the years 2010 and 2030 and their increasing longevity, mean that just as the ranks of Medicare beneficiaries begins to grow, the ratio of workers to beneficiaries will begin to decline. Even with the strong economy of the last decade and the slow growth in Medicare payments since 1997, current projections show Part A Trust Funds payments exceeding Part A income by 2010 and its assets exhausted by 2025.

As important as issues of Part A solvency are, the primary focus on Part A as a reflection of Medicare's fiscal health has been unhelpful and misleading. As the administration has made clear, Part B of Medicare, which is financed 75 percent by general revenue and 25 percent by premiums paid by seniors, is a large and growing part of Medicare. Part B currently represents about 40 percent of total Medicare expenditures and is growing substantially fast than Part A expenditures and about 5 percent faster than the economy as a whole. This means that the pressure on general revenue from Part B growth will continue in the future even though it will be less observable than Part A pressure. It also means that not controlling Part B expenditures will mean fewer dollars available to support other government programs.

However, as the committee understands, the reasons to reform Medicare are more than financial. Traditional Medicare is modeled after the Blue Cross/Blue Shield plans of the 1960's. Since then, there have been major changes in the way health care is organized and financed, the benefits that are typically covered, the ways in which new technology coverage decisions are made and other changes that need to be incorporated into Medicare if Medicare is to continue providing health care comparable to the care received by the rest of the American public.

Much attention has been given to the fact that the benefit package is outdated. Unlike almost all other health care plans, Medicaid effectively provides no outpatient prescription drug coverage and no protection against very large medical bills. Because of the limited nature of the benefit package, most seniors have supplemented traditional Medicare although some have opted out of traditional Medicare by choosing a Medicare risk or Medicare+Choice plan.

The use of Medicare combined with supplemental insurance has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with annual premiums varying between $1000 and $3000 or more. The supplemental plans have also meant additional costs for Medicare. By filling in the cost-sharing requirements of Medicare, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in greater use of Medicare-covered services and thus increased Medicare costs.

Medicare has also struggled with coverage decisions for new technology. The processes currently in place have been complicated and time-consuming and frequently have meant that seniors get coverage for new technologies years after the rest of the populations. This was true for heart and lung transplants a decade ago and was true for Positron Emission Topography (PET) until just recently.

There are also serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health-status among seniors. Seniors and others pay into the program on the basis of income and wages and pay the same premium for Part B services. These large variations in spending mean there are substantial cross-subsidies from people living in low medical cost states and states with conservative practice styles compared to people living in higher medical cost states and states with aggressive practice styles.

ASSESSING THE ADMINISTRATION'S MEDICARE PROPOSALS

The administration correctly understands Medicare needs reform in many dimensions. Medicare's benefits are clearly outmoded, but Medicare's problems extend beyond the absence of prescription drug and catastrophic coverage. Medicare needs to be modernized to accommodate the needs of the retiring babyboomers and to be viable for the 21st Century.

During the campaign, the President's long-term modernization of the Medicare proposal was modeled after the Federal Employees Health Benefit Plan (FEHBP) and the work of the Bipartisan Commission for the Long Term Reform of Medicare. The principles provided for the President's plans to reform Medicare are consistent with these models of reform but the specifics of such a reform have not yet been proposed. Instead, only the first step included during the campaign, a temporary, short-term strategy to help low income seniors and seniors with catastrophic expenses, has been presented.

The budget as presented raises at least two questions. If there is a lack of agreement about other areas of reform, should a prescription drug benefit be added to traditional Medicare now, with reform to follow some time in the future? If not, is there any place for a temporary program of prescription drug coverage and how should that program be designed?

Although I believe a reformed Medicare package should include outpatient prescription drug coverage, I believe just adding this benefit is not the place to start the reform process. The most obvious reason is that there are a series of reforms needed to modernize Medicare. To introduce a benefit addition that would substantially increase the spending needs of a program that is already financially fragile without addressing these other issues of reform is a bad idea.

I personally support reform modeled after the FEHBP. I believe this type of structure would produce a more financially stable and viable program and would provide better incentives for seniors to choose efficient health plans and/or providers and better incentives for health care providers to produce high quality, low-cost care. This type of program, particularly if provisions were made to protect the frailest and most vulnerable seniors, would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program for the plan that best suits their needs.

I am aware that the FEHBP model remains controversial with some in the Congress, but I think it's important that committee members understand that many of the most vexing problems of FEHBP are also present with the current combination of fee-for-service Medicare and Medicare+Choice plans, e.g. risk adjustment, providing user-friendly information, protecting vulnerable seniors, etc. But whatever the

model of reform the Congress chooses to pass, the direction of the reform, a timetable for its implementation and important first steps should be determined before any major, new spending commitments are added to Medicare.

A second reason to proceed with some caution is the recognition of how difficult it is to correctly estimate the cost of a new additional benefit. Our past history is this area is not encouraging. The cost of the ESRD (end-stage renal disease) program introduced in 1972 was substantially underestimated. The estimated cost of the prescription drug component of the catastrophic bill passed in 1988 and repealed in 1989 increased by a factor of two and one-half between the time it was initially proposed and the time it was repealed. The new estimate of prescription drug spending by the elderly recently released by the Congressional Budget Office forecasts drug spending will rise at an average of 12 to 13 percent per year for the next decade instead of the 11 percent per year projected last year. This means that the estimated cost of prescription drug bills already proposed, including the President's, is too low. The new cost estimate for H.R. 4680, passed last June is $213 billion over 10 years instead of the original estimate of $160 billion and the plan proposed by House Democrats would be $440 billion over 10 years rather than $330 billion.

In addition to cost and estimating concerns, important questions remain about how best to structure a pharmacy benefit. Most recent proposals have made use of pharmacy benefit managers or PBM's as a way to moderate spending without using explicit price controls. These strategies, when used by managed care, showed some promise for a few years ago although more recently they have seemed less effective. But most PBM's have relied heavily on discounted fees and formularies and only recently have begun using more innovative strategies to more effectively manage use and spending. If Medicare is to make use of PBM's, decisions will need to be made about whether and how much financial risk PBM's can take, the financial incentives they can use, how formularies will be defined and how best to structure competition among the PBM's.

All of these issues taken together suggest that legislating a standalone prescription drug benefit addition to traditional Medicare is not a good idea. Given our history, the cost is likely to be severely underestimated, the design issues are difficult, the structure and design of a reformed Medicare program are still subject to dispute and the program remains financially fragile.

The best strategy would be to agree on the design of a reformed Medicare program and begin to implement changes now. It is likely to take several years to build the infrastructure needed for a reformed Medicare program and to transition to a new program. Producing the regulations needed to implement the controversial legislation needed for a drug benefit will take at least 2 years. A reasonable interim step is to put in place a temporary program providing prescription drug coverage to help those most in need.

There are at least two ways a temporary program of prescription drug coverage might be designed. One way is along the lines of the administration's proposal, i.e., a grant program to the states that allows state to extend existing pharmaceutical assistance programs, expand Medicaid coverage or introduce new programs, following in the model of the Children's Health Insurance Program (CHIP). The advantage of this strategy is that it builds on assistance programs already existing in 26 states and doesn't require new Federal regulations. However, there are a variety of disadvantages to this strategy as well, i.e., it requires new legislation in states that don't already have assistance programs, state pharmacy assistance programs may not be good designs for a regular Medicare benefit and may set a bad precedent, it may be difficult to convince states to pursue a temporary program and ending a block grant may be more difficult than starting one.

A second type of interim strategy would be to provide pharmaceutical coverage first to those populations who already get special treatment under Medicare, that is, the qualified Medicare beneficiary (QMB's) and the specified low-income beneficiaries (SLMB's). This strategy addresses most of the disadvantages of the block grant program but it requires agreement on many of the design issues already noted and also requires the issuance of new regulations before it can be implemented. Both of these suggest benefits might not actually be provided in the near-term.

Whether or not the benefits of providing an interim program of outpatient prescription drug coverage for selected needy populations is worth the costs, is a decision the Congress will need to make. Congress might well decide it's not worth the political capital it would take and focus its efforts directly on broader Medicare reform, which will also include a prescription drug program.

If Congress does not enact Medicare reforms this year, it should be wary of using any spending that has been set aside for Medicare reform for the purpose of further increasing payments to providers. While some justification could be made for the Balanced Budget Refinement Act passed in 1999 and the Beneficiary Improvement

and Protection Act passed in 2000, the improved financial status of many types of providers under Medicare and the higher projected spending rates for Medicare in the coming decade suggest Congress should act with great caution. MedPAC recently reported that total margins for hospitals in FY2000 appear to be greater than 5 percent, up from 2.8 percent in 1999. The financial status for other providers is less clear and while a variety of changes need to be made to the way they are reimbursed, whether or not payments need to be increased should be carefully assessed.

THE ADMINISTRATION'S MEDICAID PROPOSALS

The specific programmatic changes to Medicaid and the Children's Health Insurance Program (CHIP) that the administration will be proposing are not yet available. The expectation is that the administration will introduce changes that will increase state flexibility and encourage the use of private insurance and coordination with employer-sponsored insurance.

The administration's budget does not reflect legislated spending increases in Medicaid. The budget does, however, include a savings estimate of $17.4 billion over 10 years. This reflects a proposal by the administration to further restrict the effects of the "upper payment limit" loophole. The upper payment limit has involved the use of a higher payment for purposes of collecting the Federal share of Medicaid, with a forced rebate to the states, which has allowed states to effectively increase the Federal share in Medicaid spending. The final rule published by HCFA last year partially closed this loophole but still allowed some states to continue the practice for years and expanded the arrangement for non-State government-operated hospitals. The administration proposes prohibiting any hospital plans approved after Dec. 31, 2000 from receiving the higher payment limit proposed in last year's final rule.

The concerns raised by the Upper Payment Limit practices raise a more general concern about Medicaid. The presumption underlying the current Medicaid program is that the state's share of the matching grant provides the basic incentive for states to moderate spending under Medicaid. However, the states have shown themselves to be very creative in devising financing strategies which effectively increases the Federal share of the match beyond that which exists in law. Provider taxes and voluntary donations plagued the program during the 1990's; upper payment limits and intergovernmental transfers continue to plague the program. In this environment, the interest in increasing state flexibility increases concerns as to whether state actions will be budget-neutral or cost increasing to the Federal budget. With recent CBO projections of a 9 percent average annual growth rate in Medicaid for the next decade, any further attempts by states to increase their Federal matching share and thereby reducing incentives to be cost-conscious, are worrisome. It may be time once again to consider moving to a block grant program based on the number of individuals below certain income levels or a per capita block grant covering individuals within specified income levels. In return for this increased flexibility, states would need to provide information on the health status and use of services by people covered by the grants. This would be mean the Federal Government would have more information on the effects of its program than it has with the current Medicaid program.

THE ADMINISTRATION'S PROPOSALS ON THE UNINSURED

The administration is proposing a multipronged strategy to provide support for the uninsured, including refundable tax-credits, investments in community health centers, a reform of the National Health Service Corps and an investment in a health communities innovation fund. This strategy recognizes that as important as it is to provide increased insurance coverage to the uninsured, there will be a continuing need to fund the so-called health safety net. This is both because there are likely to be substantial numbers of uninsured individuals irrespective of the precise program that is adopted and because even for some individuals with insurance coverage, there may not be adequate health resources to provide the care that is needed.

The tax credits are part of the Treasury Department's budget. The budget sets aside $26.4 billion over 10 years, some of which is for individuals who don't have access to employer-sponsored health insurance. The precise amount has not yet been released. The HHS budget includes $124 million for FY 2002 as part of a multiyear commitment to increase the number of community health centers by 1200 and double the number of people served. $400 million for FY2002 is budgeted to provide funding for innovative local organizations addressing various local health care needs. The National Health Service Corp reform primarily reflects a management effort that will improve the targeting of the neediest communities.

The question of whether the proposed refundable tax credit is likely to induce the purchase of private insurance is an area in which there is considerable debate. The decision to increase insurance coverage by providing financial assistance to individuals to purchase insurance as opposed to increasing eligibility for public programs is a first order decision that the Congress must make. The remaining budgeted items represent substantial efforts to improve the health care infrastructure.

Let me summarize my points as follows:

The administration proposes to spend $153 billion in FY 2002–2011 to modernize and reform Medicare

- Specific provisions of long-term reform not yet submitted
- Funding includes support for temporary program providing assistance to low income seniors and seniors with catastrophic drug expenses

Medicare needs to be reformed

- Current Medicare program has inadequate benefits, questionable financial solvency, excessive administrative complexity and excessive bureaucracy

Adding a standalone drug benefit without further reform is very risky

- Imprudent to substantially increase the spending needs of a financially fragile program
- Actual costs of a new benefit will be underestimated if history is any guide
- Design issues of a drug benefit are difficult and have yet to be determined

Starting now to implement a reformed program is a good idea

- Building the infrastructure will take time
- Future seniors need to know the design of the future Medicare program
- Future seniors will be different from today's seniors in terms of work experiences, health plan experiences, income and education

Temporary program for those most in need is a reasonable interim step

- Possible designs include a block grant to states or coverage limited to populations currently getting special treatment, e.g. QMB and SLMB populations
- Temporary program may not be worth the political capital it would require

Congress should be wary of spending Medicare reform funds to further increase provider payments

- Financial status of some types of Medicare providers has improved substantially

Administration proposes a $17.4 bil legislated savings from Medicaid

- Proposal involves tightening the upper payment limit provisions
- "Creative financing' by states combined with interests in increased flexibility may necessitate different structure for Medicaid than current matching grant program

Administration has multipronged strategy for the uninsured

- Refundable tax credits to encourage the purchase of private insurance
- $124 million in FY 2002 to increase the number of community health centers
- $400 million in FY 2002 to fund innovative local organizations

Mr. PUTNAM [assuming Chair]. Thank you, Dr. Wilensky.

Dr. Moon.

STATEMENT OF MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE

Dr. MOON. Thank you, it is a pleasure to be here today to testify on these important issues. Medicare is an issue that I feel very strongly about.

I wanted to start my testimony talking a little bit about some of the budget numbers in the President's recent submission of his blueprint. Then I am going to talk mainly about prescription drugs, and a little bit about other reforms of the Medicare Program.

Certainly, I agree with the administration's proposal that indicates that Parts A and B of Medicare should be thought about together. They are, for the most part, an integrated plan for most individuals, who do not worry about whether (A) or (B) is covering their service.

They do know that they pay the Part B premium, for example, but other than that this is one program, as far as most individuals are concerned. It may or may not be a good idea to formally join those two pieces.

But I would caution it is very misleading to treat the $86 billion in general revenues that fund the Part B program, along with premiums, as a deficit.

Since 1965, when Medicare was passed, general revenues have been an important part of the sources of funding for this program, and they are in the statute. In that sense, they are exactly the same as veterans' benefits or Medicaid.

If we want to accept this notion of $86 billion as a deficit, we could shove other spending from general revenues into the Part A trust fund. I can guarantee you, that quickly there would be no surplus.

Another issue I raised in the budget numbers in the administration's proposal is the shifting of home health from Part A to Part B. The document argues that this change had no consequence whatsoever, except to make Part A look better.

It does indeed make Part A look better than it would have otherwise, but it also was an indirect and intended increase in premiums on beneficiaries; that is, it did not just accidently happen.

That is about a $50 billion effect over the 10 years that we are talking about. I am sure beneficiaries would be happy to give back the $1,200 in extra premiums that they are going to pay over 10 years, and have home health go back into Part A, if we want to be purists about it.

The point I am trying to make here is that it is very important to recognize that Medicare needs financial help. It needs reforms, but it is not a solution to simply dismantle legitimate financing the way that the language implies in the administration's proposal.

I believe that we can start now to do prescription drugs in the Medicare Program, and we do not have to either do it only for low income individuals, or as part of a larger and broader reform effort.

That is not to say that broader reform efforts do not need to be looked at, or that other changes are unnecessary for Medicare; but rather, that drugs represent a vital benefit. People are at considerable risk now, and that is going to increase every year. The sources of coverage that both high and low income people have, for drug protection is quickly becoming not viable.

Only about 40 percent of all Medicare beneficiaries now have what I would call stable drug coverage, that is either through an employer-based plan, or through the Medicaid Program. Both of those areas are areas in which increasingly we hear states concerned about the cost of drugs for Medicaid, and employers concerned about the cost of drugs in their retiree packages.

So this is problem that is not going to go away on its own. It is only going to get worse. The need is there and the resources are there. We are at an unprecedented time in our history, as the administration has argued. There is a large surplus, that we could use to start a reasonable and an important program of prescription drug coverage for seniors and disabled persons.

There is another reason to think about doing prescription drugs sooner, rather than later. Some people argue that we must have reform before we can have prescription drug coverage. I believe that we really need to have prescription drug coverage before you can have reasonable reform.

A number of changes need to be made in the traditional part of Medicare, which serves 86 percent of all beneficiaries, and will continue to do so for a very long time. At present, people who are covered by traditional Medicare feel it necessary to go out and get supplemental coverage.

When they either get it from an employer, or they buy it on their own, it adds to inefficiency in Medicare, because then it tends to become essentially first dollar coverage.

If we could restructure the Medicare Program to look more like the insurance that most of us in this room have, then we could keep some cost sharing and deductibles in the program, but provide enough protection to beneficiaries that they do not have to seek supplemental protection elsewhere.

Moreover, Medigap, which is the term people use for private supplemental insurance, is increasingly an age-rated benefit. That means that people who are older pay much more for their Medigap policies than people who are younger, as compared to the premiums under Medicare, which are the same for everyone.

Adding drug coverage and making other cost sharing changes certainly would be a way to help take some of the burdens off of the very high risk seniors, by moving services into the Medicare Program. These high risk people would be better off even if they had to pay substantial Medicare premiums to get prescription drug coverage.

Moreover, it is important to think about ways in which to improve the traditional Medicare Program, such as adding disease management or case management kinds of activities, to truly coordinate care. That is important in areas where managed care is not available, and for people who have multiple illnesses, and rely upon multiple doctors, who are unlikely to join a managed care plan.

For those individuals, it is difficult to say, we are going to put you into a hypertension control program, for example, but we are not going to pay for any of the hypertensive drugs, when these are some of the expensive drugs that people take.

It is very difficult to think of ways to coordinate care, either in traditional Medicare or in managed care, unless you have a comprehensive benefit package.

The private insurance plans have recognized this for a long time. Much of their plea for higher payments is not to cover the basic Medicare-covered services, which the GAO says they get sufficient amounts for, but for the extra benefits that they want to offer. These extra benefits help to attract patients, and to treat them well and allow coordination of care, when they are covered by the plan.

So for those reasons, I believe that it is very important to have prescription drug coverage. If we move, over time, to a more private plan approach to the program, it is also important, because prescription drugs are one of those things that are risk selection attractors. That is, if you offer a very good prescription drug package, you are likely to attract sicker and more expensive patients.

If you do that, and you are a "good guy" plan, and you try to hold the line on costs, you are going to be in big trouble.

Consequently there is now a race to the bottom for a lot of managed care plans,, putting $500 caps, for example, on the amount of prescription drugs they will cover.

This is a problem that until Medicare has a benefit package that covers the things that most people need, and that are particularly important when they are sick, is going to be a problem.

In addition, we are not quite ready for a major restructuring in Medicare. We have not dealt with risk selection very well. We have not dealt with other things that need to be done to make private plans and competition work well.

Instead, I would focus on a number of other more incremental reforms. I would focus on improving risk selection, so that if we move in the direction of more private plans, we are prepared to do so.

The administration also makes a good point about the complexity of the current Medicare Program, but I would urge any of you to look at your insurance plans and the rules and coverage information available to you, as evidence of the complexity of those plans.

This is not a problem that is inherent to a Government program. This is a problem where complications of health care coverage are endemic in the United States.

Moreover, I believe that it is important to recognize that if we are going to have an improved Medicare system over time, we need to have the resources, both in personnel and dollars, to straighten out some of the legitimate problems that exist in the Health Care Financing Administration.

I would welcome a close analysis in looking at regulations, and at the organization of HCFA. I think the main thing I would caution is, do not assume that you can simply throw HCFA out, start all over again, and that none of these problems will arise in the future.

There is a lot to do before we turn the program over to the private sector. I would like to see this year be a year in which there was a lot of attention on modernizing the traditional part of Medicare, and working on adding prescription drugs.

Thank you.

[The prepared statement of Marilyn Moon follows.]

PREPARED STATEMENT OF MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE[1]

Chairman Nussle, Congressman Spratt, and Members of the committee: Thank you for the opportunity to testify today on Medicare reform issues. This is, as the budget blueprint introduced by President Bush says in its introduction, "an unprecedented moment in history." The Federal Government now has the financial ability to make needed changes in Medicare, including adding prescription drug benefits, and to put the program on a stronger financial footing. But the administration's blueprint does not acknowledge the full extent of what is needed for Medicare.

After reviewing some of the specific issues raised in the blueprint, I concentrate on prescription drug issues because this is a reasonable place to start on improving Medicare for the future. It is essential for most other types of reforms. And to address this issue effectively, sufficient resources need to be reserved for this task. I also emphasize issues facing the traditional fee-for-service part of the program, which serves 34.4 million of the 40 million Medicare beneficiaries but is often ignored when the discussion turns to "reform." For the foreseeable future, traditional Medicare will serve the majority of beneficiaries and an even larger majority of older and sicker beneficiaries. Improvements in traditional Medicare should be an important part of any reform effort.

BUDGET NUMBERS AND ISSUES IN THE BLUEPRINT

The Bush administration's blueprint for the budget recognizes some of the important issues facing Medicare in the future. Medicare was singled out by President Bush during the campaign and again in the budget submission as a program in need of expansion, particularly with respect to prescription drug coverage. The principles laid out in the document also indicate that Medicare's guarantee of access must be preserved, both in general and with respect to new technological advances, and that additional protections are needed for low income beneficiaries. All of these are laudable goals.

Further, it is appropriate to consider both Parts A and B of Medicare when examining the costs of serving the elderly and disabled. But the blueprint document goes further and treats Part B as if it were in deficit because it relies on general revenue financing. General revenues have been a major funding source for Medicare since its passage in 1965 and that obligation is spelled out in statute. It makes no sense to treat Part B as in "deficit" and thereby imply that payroll taxes should support both Parts A and B. Such an argument makes no more sense than assuming that spending on Medicaid, Veteran's benefits or even defense should be covered by the Part A Trust Fund. All of these other sources of spending have no more legal claim on general revenues than does Part B.

Coupled with the blueprint's pledge not to raise payroll taxes, if general revenues are excluded, there is no way that there will be enough revenue to support existing benefits beyond about 2005.[2] And certainly there will not be enough revenue from 2.9 percent of payroll to cover the increasing number of people who will be eligible for the program at the end of the decade or to fund a prescription drug benefit.

Part of the case made in the document for combining A and B in examining Medicare is a criticism of the shift of some home health benefits from Part A to Part B in the Balanced Budget Act of 1997. This change, which returned home health closer to how it was treated in 1966, did make Part A look better. But it is incorrect to argue that it "had no economic consequences." By shifting a majority of home health care to Part B, beneficiaries costs rise since their Part B premium is 25 percent of the costs of Part B services. Thus, this was an indirect, but intended, increase in beneficiary contributions. In fact, beneficiaries' share of combined A and B spending will rise from about 9 percent prior to the BBA to over 11 percent when the phase in of home health is completed in 2004. Over the 10 year period, that translates a per capita premium increase of nearly $1200. Most beneficiaries would not consider this a meaningless change; indeed they would likely welcome having home health returned to Part A.

This is not to say that only Part A should be considered in examining Medicare but rather that both parts should be considered with regard both to their spending and sources of income. Should there be limits or constraints on general revenue contributions to Medicare? Even those who have implicitly argued for such a limit have never proposed reducing general revenue contributions to zero.

At a time when both President Bush's document and most policy makers recognize that new benefits need to be added to Medicare and that the aging of the Baby Boom generation pose new demands on Medicare, it seems foolish to deny general revenue spending and pledge that payroll taxes will not be raised. More willingness to raise revenues is needed to assure Medicare's future. The information in the budget blueprint does a disservice to that effort.

PRESCRIPTION DRUG ISSUES

Three basic approaches to adding prescription drug coverage for Medicare beneficiaries have been suggested:

- Provide coverage only for those with low incomes—either as an initial step or as the full response;
- Provide universal coverage, but only in concert with other reforms, such as relying on private insurance plans; and
- Provide universal coverage that are not contingent upon other reforms.

The obvious advantage of offering coverage only to low-income people (as the Bush administration has proposed for the next 4 years) is cost. But this seemingly low cost approach requires a separate administrative structure (most likely state run) to determine eligibility and the menu of drugs that would be covered. This structure will take time to build and may be problematic if the program is only intended to last for several years. But, most important, a low income approach would solve only part of the problem because many beneficiaries who would not qualify face high costs and no access to reliable insurance.

The main reason to tie drug coverage to other reforms is to create a warmer reception for what may be very unpopular new requirements in other areas of Medi-

care. This has been the stance of some who propose further privatization of the Medicare program. But a drug benefit would likely be stalled while controversies over the role of traditional Medicare and private plans are worked out. Meanwhile, the plight for beneficiaries will worsen each year. Another risk of this approach is that a drug benefit would be designed that works well with private plan options, but treats coordination with the traditional Medicare program as an afterthought.

The approach I favor would deal with the prescription drug issue now, perhaps in conjunction with some other changes in Medicare, but not a full restructuring of the program. Getting it right on prescription drugs is a large task by itself. Regardless of whether the future of Medicare relies on incremental reforms or program restructuring to feature private insurers, a drug benefit is a necessary first step. Moreover, since both traditional Medicare and private plans are likely to be part of the future, any drug benefit needs to work under either scenario.

Is the $153 billion proposed in the budget blueprint enough to fund a reasonable Medicare prescription drug benefit? If the costs of prescription drugs rise at the rate that the CBO estimates over the next 10 years, $153 billion will cover a benefit that is less than 10 percent of drug spending by Medicare beneficiaries, not enough to offer the type of protection that beneficiaries need or expect. On the other hand, if the administration's $153 billion number is a net figure after achieving substantial (but as yet undefined) savings, perhaps the amount to be contributed would be much higher. Even if the number were doubled to $300 billion, however, this would only raise the contribution to an average of about 20 percent of costs of drugs, and it leaves unknown where the $150 billion in additional savings would come from.

Prescription Drugs and Medicare Beneficiaries. Prescription drugs are the primary acute care benefit excluded from Medicare coverage. Only in the hospital, a nursing home, or in a hospice will Medicare cover drugs. But drugs are now, more than ever, a critical part of a comprehensive health care delivery system. Lack of compliance with prescribed medications can raise health care costs over time. And for many who need multiple prescriptions, the costs can be beyond their reach.

An initial look at supplemental coverage might suggest that there is little need to expand benefits, except perhaps for those with very low incomes. True, many beneficiaries do have supplemental insurance plans. But, if the reliability of insurance is taken into account, many more have unmet needs. Medicare beneficiaries supplement their basic benefits from four sources. The first two, employer-based retiree insurance and individual supplemental coverage (which is referred to as Medigap), are provided by private insurers, while Medicaid, a public benefit, subsidizes many low-income beneficiaries. Fourth, Medicare contracts with private plans, mostly health maintenance organizations (HMOs), to serve beneficiaries who choose to enroll. Such plans often cover services that basic Medicare does not. Such supplemental coverage varies in quality, beneficiaries' access, and the degree to which the added coverage relieves financial burdens. Only employer-based retiree coverage and Medicaid offer reliable drug benefits, and even then not to all their enrollees.

Employer-based plans normally offer comprehensive supplemental insurance, including drug benefits, and subsidize retirees' premiums. Thus, these plans both reduce out-of-pocket expenses and increase access to services. But such plans are limited to workers and dependents whose former employer offers generous retiree benefits. As a consequence, these benefits accrue mainly to higher income retirees.

Medicaid, which also offers generous "fill in" benefits, including drugs, is limited to persons with incomes well below the Federal poverty level. low incomes. Since Medicaid is a joint federal/state program, states have latitude in establishing eligibility and coverage. And although all states cover prescription drugs, many have limits on who is eligible and what drugs are included. Concern about the high costs of prescription drugs suggests that states are unlikely to expand these benefits on their own, (although some are active in providing separate drug programs).

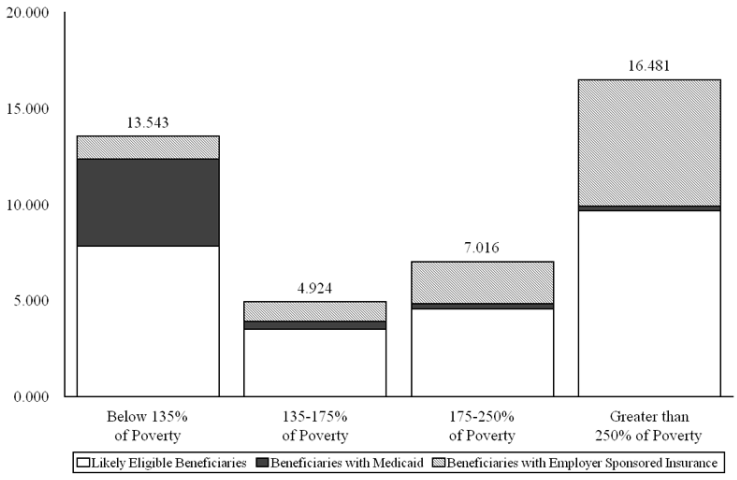
Medigap plans are rarely a good bargain for most beneficiaries. Beneficiaries pay the full costs of such plans. Medigap options that include drugs have become prohibitively expensive for many beneficiaries, particularly the very old who must pay substantially higher premiums than those aged 65 to 69, for example. And even though they can charge steep premiums, many insurers are refusing to offer options with drug coverage. Most likely, Medigap drug coverage will soon be viable only for those who have been grandfathered into a reasonable plan.

Finally, beneficiaries can opt to go into a Medicare + Choice plan. These private plans generally offer additional benefits at a lower cost than Medigap does, but require enrollees to meet certain conditions, such as agreeing to go only to doctors and other care providers who are on a prescribed list. Since 1997, these plans have either shrunk their benefits packages or raised premiums (over and above Medicare's Part B premium). Drug coverage has either been dropped altogether or stringent

caps have been placed on the amount covered. Moreover, a number of plans have pulled out of Medicare, causing beneficiaries to scramble for new arrangements.

In sum, while a substantial number of beneficiaries now have drug coverage, the share with reliable coverage (employer-based or Medicaid) is considerably smaller. Only 39 percent of Medicare beneficiaries have reliable coverage, and an even smaller percentage have it for a full year. Further, states and former employers who now support good coverage may pull back as prescription drugs become even more expensive, intensifying demand for drug coverage in the future. Figure 1 indicates how vulnerable beneficiaries are. It identifies those most in need of coverage across different levels of economic status (shown as income as a share of the poverty guidelines). The white areas stand for beneficiaries who have no coverage or who now rely on Medigap or Medicare+Choice plans.

Figure 1
Number of Beneficiaries by Eligibility Status, 2002 (in millions)

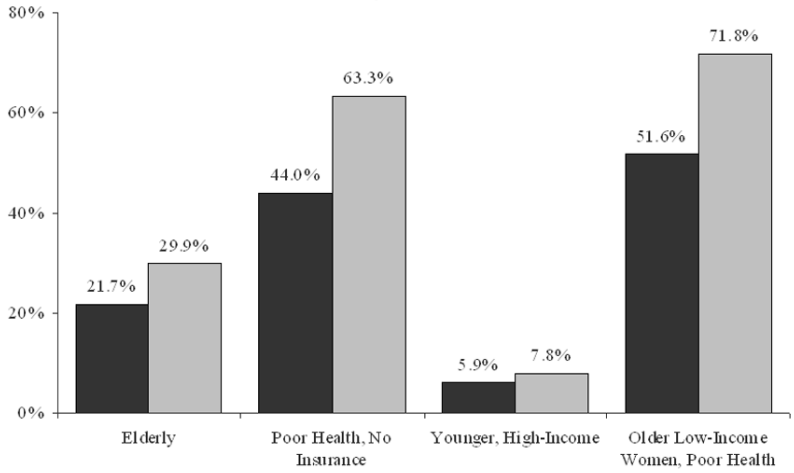


Source: Urban Institute Analysis of the 1997 Medicare Current Beneficiary Survey

As Figure 1 also shows, in all groups a majority of beneficiaries is without reliable coverage. Cutting benefit eligibility at 135 percent or 175 percent of the poverty level would not do away with the problems that beneficiaries face of obtaining reliable prescription drug coverage. In fact, the group with incomes between 175 percent and 250 percent of poverty (about $15,000 to $20,000 for a single person) get little coverage from either employer-subsidized or Medicaid coverage. They are in many ways as vulnerable as the truly poor. If eligibility extends to 250 percent of poverty, that would include over 60 percent of the Medicare population. And even of those with incomes above 250 percent of poverty, only 41 percent have reliable coverage.

Spending on drugs, on average, is about the same across all income groups. In other words, the importance of this benefit does not decline with income, although the ability to pay does improve. And, even more important, the burdens on Medicare beneficiaries will continue to rise, even with no policy changes. Figure 2 projects out-of-pocket spending for several groups of beneficiaries. Much of the growth in out-of-pocket burdens over the next 25 years reflects growth in the cost of prescription drugs.[3]

Figure 2
Projected Out-of-Pocket Spending as a Share of Income Among Cohorts, 2000 and 2025



Source: The Urban Institute's 1999 Medicare Projections Model

Issues Crucial to Beneficiaries. As shown above, prescription drug costs are a large and rising expense that many beneficiaries must face. The willingness of Medigap beneficiaries to pay high amounts to obtain drug coverage and of Medicare+Choice beneficiaries to enroll and switch plans to obtain drug coverage suggest how much beneficiaries value this benefit. It is likely, then, that they would pay higher premiums to obtain this coverage. But, low income protections and a universal subsidy would be needed to make this an effective benefit.

If the drug benefit is to be a voluntary option, a subsidy and some enrollment restrictions would be even more important to insure that a broad range of beneficiaries would join the Medicare plan. Consider Part B of Medicare. It is a voluntary benefit, but a subsidy makes it sufficiently valuable to attract almost all beneficiaries. As a consequence, risk selection does not raise the costs of the coverage.

The structure of any prescription drug benefit will affect access and use. If a standard drug benefit were offered as an option through the Medicare program, the administration of the benefit could be contracted out to private companies just as Medicare now does for its payments to hospitals, physicians and other providers. This approach hews closely to the practice of the basic Medicare program.

Alternatively, the private sector could be used to establish voluntary prescription drug options. Usually this tack is proposed as a way to allow coverage to vary from plan to plan and across the country. But this private option works better for enrollees who choose to be in private plans than for those in traditional Medicare because the latter would face confusing choices. Already, most beneficiaries have two types of insurance. Adding a third separate benefit, run by yet another insurer, would undoubtedly add to the complexity and confusion that already plagues many beneficiaries. Breaking up coverage makes little sense from an insurance standpoint—one reason why the insurance industry has not been interested in standalone drug plans.

Further, even for those in private plans, permitting variation in benefit packages offered creates a serious disadvantage. Allowing individuals to choose what is "best" for them is likely to separate the sick from the healthy and make it difficult to make sure that the neediest can afford coverage. Most Medicare beneficiaries who expect to use few drugs would choose a plan with no deductible, low co-insurance, and a low cap on benefits. Those who anticipate using more or higher priced drugs might want greater overall protection even if they have to pay a deductible or high coinsurance rate for their initial purchases. A standardized benefit takes away one tool for achieving risk selection.

Finally, the generosity of the plan is a critical element. Even the most generous plans will not be as comprehensive as what most younger families have, even though the needs are greater for Medicare beneficiaries. Protections ought to be generous enough to be valued by those who enroll, although the costs of a drug benefit are likely to be high and grow rapidly over time.

OTHER REFORM ISSUES

Drug coverage represents a logical first step in reform, helping to smooth the way for other Medicare changes. It also makes sense to carry out some other reforms simultaneously, and put in place changes that may pave the way for later, more extensive changes.

Improving the Traditional Medicare Program. One major criticism leveled at fee-for-service Medicare is that when it is combined with supplemental insurance, many beneficiaries have nearly first dollar coverage. If beneficiaries face cost sharing requirements, that might make them more conscious of the costs of care. The Congressional Budget Office has long contended that this approach substantially raises the costs of Medicare. Further, dual coverage generates excess administrative costs that beneficiaries must cover.

Adding prescription drug coverage would reduce the need for other supplemental insurance, but probably not enough to encourage beneficiaries to drop their Medigap plans. Other changes in cost sharing would be needed, such as reducing the very high Part A deductible and limiting the total amount of cost sharing that any beneficiary would owe. A more rational Medicare cost-sharing package would not have to be an expensive addition, especially if it increased cost sharing in such areas as the Part B deductible that are low compared to the private sector. These changes could help defray higher costs elsewhere. If the basic Medicare benefit could be made to look more like insurance that most working families have, with good protections and reasonable cost sharing, the traditional Medicare program could satisfy both beneficiaries and those worried about costs.

In addition, moving more basic health care services under the Medicare umbrella would substantially better protect sicker and older beneficiaries. The very old get Medicare at community rates (i.e. where everyone pays the same premium), but they depend more on Medigap for their supplemental coverage even though these policies are age rated and hence are very costly. These beneficiaries are least able to afford Medigap premiums and could benefit if they were covered under Medicare instead. And in the case of younger disability beneficiaries, Medigap is often not available at all.

Another advantage of expanding the traditional Medicare benefit package is that further reforms that might coordinate care through disease-management or other programs can be effective only if the full range of care is available. The lack of prescription drug coverage and the reality of very high out-of-pocket costs increases the likelihood of noncompliance. Such noncompliance would make it hard to achieve overall savings since the extra expense of coordination of care would not be offset by better outcomes. For example, it makes no sense to have a program to control hypertension if beneficiaries cannot afford the drugs necessary to combat hypertension.

Finally, the current Medicare+Choice plans are able to offer prescription drug benefits in part because they receive Federal payments in excess of what it costs to provide the current Medicare benefit package. The General Accounting Office has found that plans get payments more than 13 percent higher than what it would cost in fee-for-service to provide the basic benefits. Even the HMO industry now makes its case for higher payments over time as necessary to retain a "desirable" benefit package—not just the required Medicare benefits. The problem is that many of the 6 million beneficiaries in HMOs thus get subsidies for drug coverage, but those in traditional Medicare—who are sicker on average and more likely to need drugs—do not. Adding a prescription drug benefit to Medicare would help both Medicare+Choice enrollees and those in traditional Medicare. And since partial subsidies are already in place for HMOs, accounting for this could lower the costs of providing universal coverage.

In addition to improvements in Medicare from adding a drug benefit, other modernization efforts will be important as well. The administration's criticisms of the current program and call for "modernization" can be viewed as a need for restructuring or as a call for improving the current system. The latter effort should be undertaken regardless of what happens in restructuring of Medicare.

Much of the administration's criticism about Medicare centers on complexity and bureaucracy. Certainly the Health Care Financing Administration's (HCFA) operations should be improved. But it is also important to determine what the problems

are and how to solve them rather than just pinning the blame on government bureaucracy. Over the years, the responsibility of HCFA has grown substantially, but its resources to deal with these responsibilities both in dollars and personnel have not expanded. Second, the Congress has taken a strong interest in Medicare and dictated many policies at a very disaggregated level.

It is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many workers and their families find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, understanding the bills when they come due months later, and the need to appeal denials of care to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. The goal should be to reduce these burdens throughout health care, but to lay the issue at the doorstep of only Medicare is misleading. More resources are needed to expand oversight capabilities and bring in professionals who have private sector experience.

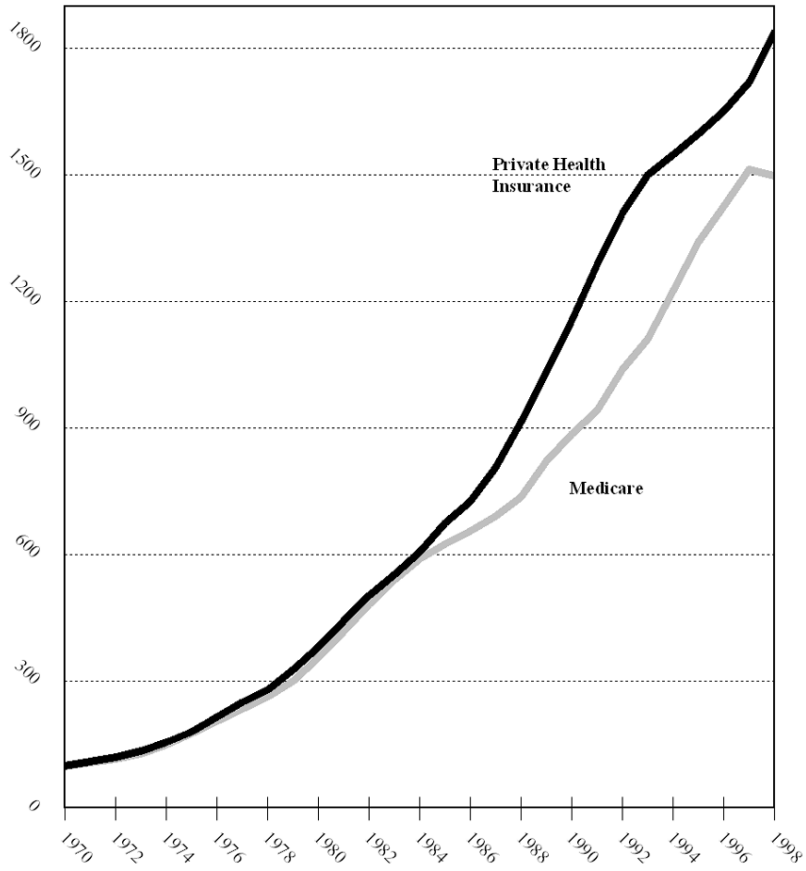
Further, the traditional Medicare program needs to have more flexibility to deal with providers of care and make judgement calls that the Congress has often prevented. Experiments with new ways to coordinate care in a fee-for-service setting need to be undertaken. Improved methods of payment to private plans and better measures to control for risk selection are needed both in the current system and are necessary before beginning a more extensive restructuring effort. Relying on private plans to make decisions is unlikely to result in the government observing a hands-off approach. Nor should it. Medicare is an important program that needs careful oversight to protect the beneficiaries it serves.

Restructuring Options that Rely on the Private Sector. Proposals to rely more upon the private market to offer coverage to Medicare beneficiaries would also be helped if a reasonable prescription drug benefit were in place. Not only does managed care need a comprehensive benefit package to perform well, but such a benefit would help reduce the incentive for risk selection that private plans now face. Plans would find it difficult to voluntarily add any benefits—such as drugs—without attracting sicker patients. They would likely respond in the same way that current Medicare+Choice plans have responded by paring back drug coverage.

For these reasons, competition will work much better if the basic plan that all must offer is sufficiently comprehensive and standardized. This would still leave ample room for adding other benefits or competing on price. Until adjustments that could account for differences in health status are improved, it will be difficult to use competition in positive ways. The benefits to plans of seeking good risks are simply still too tempting. It is easier to make profits by attracting healthy patients than by coordinating care.

Some of the steps described above in connection with reforming the current program need to be in place and working well before a full restructuring of Medicare is undertaken. This is particularly the case if traditional Medicare is put at risk and becomes inordinately expensive over time. That would harm the most vulnerable beneficiaries, offsetting any gains that might result in improved efficiency or choice. Further, concerns raised about managed care for younger Americans and the issue of whether such an approach can actually offer cost savings need to be addressed before making aggressive moves toward this type of change. Figure 3, for example, compares Medicare per capita growth with growth in spending by private insurance over nearly a thirty years. Medicare's track record is substantially better than the private sector.

Figure 3
Cumulative Per Capita Rates of Growth in Health Care Spending, 1970-1997



Source: The Urban Institute's Analysis of National Health Expenditure Data

Improving Beneficiary Education and Information. Another factor important to the success of Medicare reform is to give beneficiaries more say in decisions about their own care. But simply giving them responsibility (for example, requiring them to choose a plan) will not work unless they have the tools to respond. Credible, independent sources of information will be essential.

A good place to start this educational effort would be with the prescription drug benefit. A publicly funded but independent organization that would provide information on the quality of generic drugs and the extent of equivalence across name brands in the same drug categories, for example, could help beneficiaries to make more informed choices. Reassurance that a less expensive drug is just as effective will be more powerful coming from a credible source than from a plan with a financial stake in that decision. Prescription drug coverage will be expensive; so government should invest in the resources necessary to make better decisions. This information could also help hold down costs of drugs both in Medicare and in the private sector.

Financing. Expanding benefits is a separable issue from how the structure of Medicare evolves over time. It is not separable from the issue of the cost of new benefits, however. Adding drug coverage clearly raises financing issues. New revenues, most likely from a combination of beneficiary and taxpayer dollars, will be required. The administration's proposals ignore this key issue and in fact make it worse by treating general revenue as "deficit" financing and arguing for no increase in payroll taxes. No restructuring effort or other reform will be sufficient to remove the need for greater resources over time.

CONCLUSION

A familiar refrain for critics of Medicare is that it is a "Cadillac" program, but the model year is 1965. This criticism is often leveled at Medicare's fee-for-service system. In fact, the Medicare delivery system has undergone a large number of changes and reforms. In the 1980's, it was a leader in pushing for payment reforms and its per capita growth rates were lower than that of private insurance. It now has a private option dominated by managed care plans, and increasingly reforms have sought to give administrators of the program further flexibility in managing the costs of care. Where the criticism is more on target, however, is in the area of benefits. The basic structure of the Medicare benefit package has changed little since 1965.

The current patchwork approach to provide drug benefits through private insurance, such as we have now, is seriously flawed. Prescription drug benefits generate risk selection problems; already the costs charged by many private supplemental plans for prescription drugs equal or outweigh their total possible benefits because such coverage attracts sicker than average enrollees. A concerted effort to expand benefits is necessary if Medicare is to be an efficient and effective program. This commitment will require substantial new resources, but adding a prescription drug benefit is a logical place to begin reforms of Medicare. It does not make sense to hold beneficiaries hostage in order to pass other unpopular and unproven changes in the program.

Too often the solution proposed to complexity or inefficiency is to start over with a whole new system. But that approach carries no guarantees of success. Improvements in the current Medicare system could test out whether more restructuring will work well for Medicare beneficiaries. There is a great deal to do before major reforms are ready for "prime time."

ENDNOTES

1. Senior Fellow, The Urban Institute. The views expressed herein are those of the author and do not necessarily reflect those of the Urban Institute, its trustees, or its sponsors.

2. This is based on last year's Trustees numbers. The outlook would likely be a little better this year, but not by very much.

3. Although these numbers are dramatic, they still may understate possible increases in out-of-pocket costs. For example, we do not assume changes in insurance coverage over time, and we assume relatively modest drug growth of 10 percent per year for 10 years and then the same growth rates as for other health care services.

Mr. PUTNAM. Thank you, Dr. Moon.

Dr. Saving, welcome to the committee.

STATEMENT OF THOMAS R. SAVING, DIRECTOR, PRIVATE ENTERPRISE RESEARCH CENTER

Dr. SAVING. Thank you very much for the opportunity to discuss the challenges Medicare faces in the future.

I am going to have a little disclaimer here, too, because I am a Public Trustee of the Social Security and Medicare Trust Funds.

I want to say, at the outset, my comments here do not represent the opinions of the Social Security Administration, or the Health Care Financing Administration, or any part of the things from which I am a trustee. They are really my opinions, as an economist.

I want to comment briefly on the reforms that affect Medicare programs, expenditures, and revenues. Most reforms, from those

enacted as part of the BBA in 1997, the recommendations of members of the National Bi-Partisan Commission on the future of Medicare, and a lot of our discussion here today, have concentrated on reducing the current expenditure levels, and on future expenditure growth.

However, reforming the program's finances also deserves our attention, and it is becoming an increasing problem, as we look at it. Let me have Figure 1.

To get a feel for the future tax implications of current Medicare, I present in the figure total Medicare expenditures. Now what I have here, I express those all in terms of taxable payroll, because that is a way that we happen to tax at least Part A of Medicare and, of course, Social Security.

It just gives us a feel for what these numbers are like. It is the sum of both SMI, Part B, and Part A of Medicare. The deficits that you might see there, Marilyn does not want to call those deficits. We can call them whatever we like. What they are—they are expenditures that have to come from the Treasury—and do not come from the dedicated sources of income for Medicare, Part A or Part B.

So what I have in here as revenues are the part that consumers or beneficiaries pay in Part B plus Part A taxes. The difference has to come from the Treasury, however we want to talk about that.

What we can see is that the difference between revenue and expenditures shows the magnitude of the funding shortfall each year, and that has to be made up from general revenues. In 2000, that deficit was 1.13 percent of payroll; and by 2040, the transfer from the Treasury is going to be 7.5 percent of taxable payroll. By 2070, it is going to be 13.5 percent of payroll.

If you combine that with what the current Social Security is going to take, we are looking at transfers from the Treasury to these programs that are 27.5 percent of total payroll. Let me put Figure 2 up there.

There is another way to talk about the financial challenge arising for Medicare and Social Security, and that is to calculate their accrued liabilities.

The debt that we have promised to the future is exactly the same kind of debt that we have when we talk about the general publicly held debt, for which we pay interest payments. The only difference is that if we do not make the interest payments, Wall Street bangs us on the knuckles and lowers the value of all Government bonds. In this case, of course, Congress can immediately just take away these benefits, if they want to.

What I have done here is to calculate the value of our promises. I have actually discounted them by a fairly high discount rate, because they are uncertain. As a matter of fact, in the past, when Social Security has gotten into difficulties, we have taken some of the benefits away.

So if that is going to happen in the future, in any case, the size of these debts are $8.8 trillion for Social Security, and $8 trillion for Medicare. These two debts, every bit as much as the publicly held debt, are some five times the publicly held debt.

So if we are going to use the surplus to reduce debt, we can use it just as well to reduce this debt, as to reduce the so-called nominal debt that we have outside.

Let me go back to Figure 1. Regardless of the long-range rate used to estimate future expenditures, Medicare is underfunded by its current revenue sources. As the figure illustrates, the growth of Medicare will have a dramatic impact on the funds projected to be transferred from the rest of the budget to Medicare.

Accelerating Medicare costs will, in the absence of meaningful reform, not only drive Medicare spending to levels that may be unsustainable for future generations of taxpayers, but will create a currently unfavorable environment for adding much needed prescription drug coverage.

The projection of future Medicare costs incorporates assumptions about demographic changes in the future, because we make a lot of assumptions when we are doing this. These include income growth, health care market structure, and medical technological progress.

We cannot do much about demographics. As a matter of fact, because this baby boom problem exists in the entire developed world, the future assumptions that we are making about immigration are likely to be very optimistic; because all of the developed world is going to be competing for immigrants.

The working population in Japan and in all of Europe is going to be declining rapidly because they have a bigger baby boom population problem than we do.

In order to produce and have workers in their countries, they are going to have to import people. They are going to present us with much greater competition for immigrants than we have ever had in the past. I think that we are making optimistic immigration assumptions in the demographics.

That aside, the demand for medical care, of course, given the assumptions of the technical panel that HCFA had and that were presented in their results in November, is suggesting that our past projections, and the projections that I have here are based, in fact, on that technical panel's assumptions, that health care is likely to grow more rapidly than gross domestic product. Their suggestion is 1 percent more rapidly, and that is what these numbers project.

So we are not going to do much in those two areas. So where we have to go, we are left relying on changing the structure of health care markets to encourage competition.

Such competition has the potential of reducing the current level of expenditures through demand reductions and price competition, and at the same time, encouraging the development of new technology, which is directed toward cost reduction. That is something that does not happen now, since buyers do not care what medical care costs. Inventing a new technology that makes it cheaper does not actually generate any revenue for you.

Fee-for-service Medicare, combined with supplemental insurance, effectively gives many beneficiaries nearly first-dollar coverage. Without real cost sharing requirements in place, beneficiaries tend to have little regard for the price of health care services.

When consumers do not care what services cost, you can be certain that suppliers of these services will not care what they cost.

In addition, the benefits of developing cost-saving technology are positive only if those who demand services care about cost. Thus, technological changes that increase our ability to find solutions to current conditions for which there are no treatments result in higher expenditures.

With proper incentives, however, such expenditure increases may be wholly or partially offset by the development of cost-reducing technology.

We can develop an estimate of the demand effect of introducing no first-dollar coverage, and it is something that Marilyn also discussed, by relying on the results of the Rand insurance experiment, which was done in the 1980's.

Updating that study to a $2,500 deductible policy results in a 24-percent reduction in medical care expenditures. Those expenditure reductions only are reductions in demand for health care at existing prices.

Once you had that size, and take the Medicare population times $2,500, the size of that market will make providers compete on price to get into that market. Once they compete on price, prices will be considerably lower, and cost-reducing technology will be encouraged.

Up to now, attempts to constrain expenditure growth really have relied on price controls. We have thousands of years of historical evidence that suggest that price controls do not work, and the expanding choice is the second aspect. That is the development of Medicare Plus Choice.

Unfortunately, reimbursing private insurers, based on pre-set risk adjusted payment rates as was done with Medicare Plus Choice, induces providers to screen patients.

An alternative to establishing risk-adjusted reimbursement rates is the competitive bidding process in which suppliers bid for each type of patient, rather than HCFA telling suppliers what each type of patient is going to be reimbursed, on the basis of last year's averages. In this way, suppliers reveal their reservation prices, rather than HCFA attempting to determine the correct prices.

So how do we move ahead on bringing competition into the picture at a time when many are suggesting that Medicare's coverage be expanded to include prescription drug coverage? Now there are convincing medical and economic reasons for adding prescription drug coverage.

The current coverage, drug therapies that may be cost effective, cost consumers more than perhaps more costly interventions. As a result, technological advances are tilted toward the development of such more costly interventions.

Introducing pharmaceutical coverage would level the playing field for consumers of health care, and perhaps lead to technological advances that result in lower cost therapies. However, a plan providing universal drug coverage with no conditions about other reforms would be financially irresponsible, in this case.

Adding full drug coverage to all Medicare beneficiaries would effectively replace current private sector financing with public financing. We can expect that in 2001, we are looking at at least 1.3 percent of taxable payroll, which would be added to the large subsidies already from the general fund of the Treasury.

Let me put Figure 3 back up there for a moment. This gives me one thing that I think is a little bit of an aside. Look at what has happened to prescription drug prices, and as we know, the inflation in prescription drug prices has exceeded that in the rest of health care.

There is a good reason for that. The reason for that is the growth of third party payments. What this figure really shows you is that, for the period from 1960 through the 1970's, prescription drug prices rose at an annual rate of only 1 percent. However, third party payers only covered, on an average, 16 percent. That meant that individuals were paying 84 percent of the price of prescription drugs. They cared about what it cost.

In the last 20 years, what has happened is, we have had a huge increase in the share. Now it is up to 73 percent of prescription drugs that are paid for by somebody else.

On the average, for the second part of that period, it was 52 percent. You can see what happened to prescription drug prices. When customers do not care what it costs, suppliers do not care what it costs.

I think that is an important lesson that we have to learn. We have to find a way to restructure Medicare so suppliers care what it costs. If we cannot do that, we are going to have a problem.

Now the last thing I want to discuss is, how are we going to solve this payment problem that we have and that is significant?

In the past, I have presented in Washington a couple of times a method of trying to pre-pay Medicare, and the notion of having each generation pay, in advance, for its own Medicare.

This is the system that I have worked out. We will put up the next table, perhaps. The transition path that I have studied is the following one. All workers born in 1946 or later, and those are all the baby boomers, are in the pre-paid system. Everybody older remains in traditional Medicare.

Beginning today, individuals in the pre-paid system establish and fund a private retirement account that is going to purchase health insurance for the rest of their lives, once they reach retirement age.

This sounds like it is a very big deal; a very big, tall task. It is a tall task but, in fact, it can be done. I think you should look at the numbers there. You can see what they are.

The table shows the lifetime contribution rates on labor earnings for new labor force entrants, assuming that per-capita benefits are going to grow at GDP per capita, plus 1 percent, which was the technical panel's recommendation.

As you can see, I present two things on this table; one which is current Medicare, and the other one is a $2,500 deductible policy.

You can see that if we have a conservative rate of return for these accounts that are going to pre-purchase private health insurance, we are looking at a contribution rate of 2.68 percent for current Medicare. That is less than current Medicare taxes. If we assume a $2,500 deductible policy, it would be 2.27 percent.

If we look at the rate of return as the marginal productivity of capital in the United States, then we are looking at a contribution rate of 0.86 percent, or 0.73 percent for a $2,500 deductible policy.

There are other favorable consequences of pre-paying retirement insurance. With prepayment, capital stocks rise and income rises. By pre-paying benefits, future payroll taxes will be reduced, producing significant efficiency gains.

Let me put Table 2 up. What it does is show you the path of tax rates that actually would pre-fund Medicare. The first column shows the time path of current Medicare, and what its tax rates would look like. The second column shows you the time path of contributions that would pre-fund Medicare for everybody.

As you can see, in the year 2000, or actually 2001, those tax rates are higher than current taxes. What I have done is, with the 4.17, I put the current contribution of Congress, of the Treasury, to Part B, in those tax rates, so that they can be compared.

But as you can see, by 2018, the tax rates are lower with the prepaid system, and forever after, they are lower. In fact, they eventually go down to 1.24 percent.

Why are we talking about Medicare today? It is worth thinking about that. We are not talking about the rising expenditures on computers. Why is that? It is because Congress is not paying for computers. Congress is paying for Medicare.

What we want to do is reduce the cost borne by taxpayers. But also, it is not clear that we are ever going to pay the costs that I am indicating up here. If we are not going to pay them, that means benefits are going to be reduced.

First, Medicare should be thought of as a single insurance package rather than in terms of the historical acts that produced separate hospital and supplemental medical insurance programs.

Second, making suppliers and consumers of medical care cost-conscious requires that both groups care about prices. This can be accomplished by eliminating first dollar coverage, and a provision of a defined contribution Medicare benefit.

Then some form of additional premium support for lower income elderly could address the concerns that they will not get the care they need.

Because we inherited distribution of health situations, however, such defined benefits must be risk-adjusted. The risk adjustments must be determined by the marketplace, and not by HCFA, if we are going to make this work.

With this form of benefit, we can probably add prescription drugs and catastrophic coverage in a cost-effective way. Perhaps for the same costs that we are now imagining, we can have both prescription drugs and catastrophic coverage, which are the two elements of Medicare. It is particularly catastrophic coverage that forces people to buy Medigap.

Finally, I have observed in the recent discussions about fiscal priorities an almost universal agreement to reduce the Government's debt. I am emphasizing, as I did in the figure that talked about the debts, that Medicare and Social Security commitments made to current retirees and future retirees represent Government debts in exactly the same way as the publicly held debt that is traded on the New York Stock Exchange does.

If we are going to try to reduce debt, I think it makes more sense to reduce this debt than the publicly held debt.

Thank you.

[The prepared statement of Thomas R. Saving follows.]

PREPARED STATEMENT OF THOMAS R. SAVING, DIRECTOR, PRIVATE ENTERPRISE RESEARCH CENTER

INTRODUCTORY COMMENTS

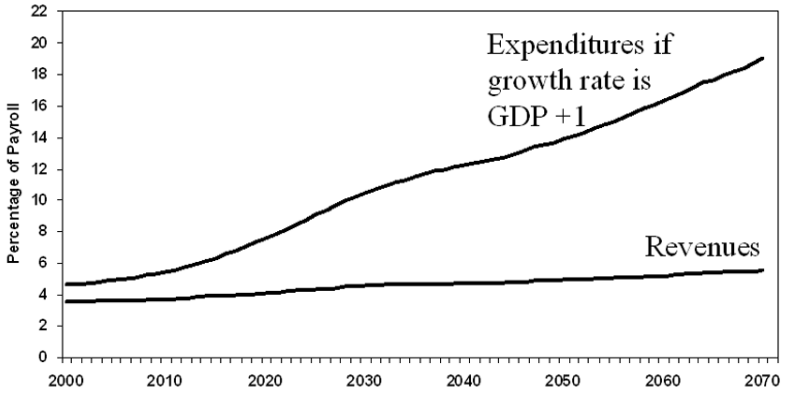
Thank you for this opportunity to discuss the challenges Medicare faces in the future. Since October of last year I have had the pleasure of serving as a Public Trustee of the Social Security and Medicare Trust Funds. During these few short months my already high regard for the professionalism and objectivity of the actuaries who prepare the Trustees Reports has risen. Let me say at the outset that my comments do not represent the opinions of the Social Security Administration or the Health Care Financing Administration.

I would like to comment briefly on reforms that affect the Medicare programs expenditures revenues. Most reforms, from those enacted as part of the Balanced Budget Agreement in 1997 to the recommendations of the majority of the members on the National Bipartisan Commission on the Future of Medicare, concentrate on reducing expenditure levels and expenditure growth. Reforming the program's finances also deserves attention. Currently, health care consumption of the elderly is paid for by tax revenues. Even if the cost containment reforms are successful in moderating expenditure growth, the tax bite will still undoubtedly grow. For this reason, I investigate an alternative to transfer payment financing. In the last section of this report I will introduce the simulated effects of making a transition to prepaid retirement health insurance.

MEDICARE REVENUES AND EXPENDITURES

Figure 1 presents total Medicare expenditures expressed as a percentage of taxable payroll along with the system's dedicated revenues. The Hospital Insurance (HI) portion of Medicare has a dedicated payroll tax of 2.9 percent which is supplemented by revenues collected as a result of taxing Social Security benefits. The Supplementary Medical Insurance (SMI) portion of Medicare is financed with a combination of premium payments and general revenue taxes. While these two parts of Medicare are usually discussed separately, they are part and parcel of the overall Medicare program and any reform of Medicare must deal with all of Medicare. As such, the remainder of my remarks will treat the entire Medicare program, that is, the sum of both the HI and SMI parts of current Medicare.

Figure 1. Medicare Expenditures and Revenues



Total HI and SMI expenditures are estimated assuming that the long-run per beneficiary expenditure growth rate is equal to per capita GDP growth plus 1% rather than long run real wage growth based on the Recommendations the technical review panel. Revenues are payroll taxes plus revenues from taxation of Social Security benefits plus SMI premium payments equal to 25% of SMI expenditures.

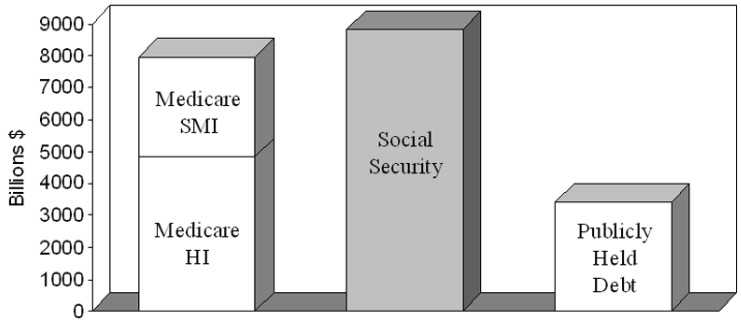
The revenues depicted in Figure 1 are the HI tax revenues and the premium payments required for participation in SMI. The latter revenues are set to 25 percent of the SMI expenditures. The expenditure estimates depicted in Figure 1 are based on the Health Care Financing Administration (HCFA) Technical Panel recommendations released in December of 2000 that long run Medicare expenditures should be assumed to grow at a rate equal to per capita GDP growth plus 1 percent.[1] The technical panel charged with reviewing the financial projections in the Trustees reports maintained that rapid technological changes in medical care and the historical evidence, among other reasons, justify a higher growth rate. Health care expenditure growth faster than GDP growth implies that the share of income being dedicated to medical care will continue to rise indefinitely and that the share of non-health care will fall indefinitely. Importantly, this assumption does not imply that in the long run all GDP will be health care.

The difference between the revenue and expenditure series shows the magnitude of the funding shortfall in each year that must be made up from general revenues. In 2000 the difference was 1.13 percent of a payroll, but by 2040 the transfer from the rest of the budget will grow more than sixfold to 7.54 percent of payroll. By 2070 the differential will grow to a staggering 13.5 percent of taxable payroll.[2]

Another way to quantify the financial challenge arising from transfer programs like Medicare and Social Security is to calculate their accrued liabilities. These accrued liabilities are presented in Figure 2. The accrued liabilities of Medicare and Social Security are equal to the value today of what is owed to current program participants. The present values are calculated using a 5.5 percent real discount rate. This rate is higher than the real government borrowing rate, reflecting the uncertainty associated with receiving future payments from the programs.

Figure 2. Federal Government Debt

(No Dedicated Revenue Offset)



Author's estimates of the Medicare and Social Security debts. These implicit debts are equal to the present value of the programs' accrued liabilities. The present values are calculated using a 5.5% real discount rate. Medicare SMI is net of premium payments.

Social Security's accrued liabilities are the present value of the cumulative benefits all current taxpayers and retirees can expect to receive based on their earnings up to the year 2001. For example, the accrued liabilities owed to today's 65 year olds are the benefits they will receive for the rest of their lives. For 45 year olds, it is the present value of the future benefits they would receive based on their first 23 years in the labor force, assuming they started working at the age of 22. For Social Security the accrued debt is estimated to be $8.8 trillion in 2001, roughly 2½ times greater than the national debt.

Medicare's accrued liabilities are calculated in a similar manner. Again, a 5.5 percent discount rate is used, but since benefit payments are not tied to past earnings like Social Security's, the accrued liabilities are the present value of expected benefits for all individuals who are vested in the program. Anyone who qualifies for Social Security by working and paying taxes for at least 10 years or who is married to a qualified beneficiary can receive Medicare. Thus, almost everyone over the age of 32 is vested in Medicare. The present value of SMI benefits are net of expected

premium payments. Together the estimated implicit debts of the Hospital and Supplementary Medical Insurance programs are equal to $8 trillion dollars in 2001.

REFORMS AIMED AT REDUCING EXPENDITURES

Regardless of the long range growth rate used to estimate future expenditures, Medicare is underfunded by its current revenue sources. As Figure 1 illustrates, the growth of Medicare will have a dramatic impact on the funds projected to be transferred from the rest of the budget to Medicare. The accelerating Medicare costs will, in the absence of meaningful reform, not only drive Medicare spending to levels that may prove to be unsustainable for future generations of taxpayers, but has already created an unfavorable environment for adding much needed prescription drug coverage to the beneficiaries' benefit package because any efforts to expand benefits would inevitably worsen Medicare's financing situation. The goal of most reform proposals is to reduce the level of expenditures and/or the growth rate in expenditures.

Projection of future Medicare costs incorporates considerations on future demographic change, income growth, health care market structure, and medical technology progress. There is not much that can be done to manipulate the demographic trend, although, as I will argue later, that prepaying Medicare would go a long way to help cope with the expected hike of Medicare costs when the tidal wave retirement of Baby Boomers comes.[3] Demand for medical care tends to increase with income growth, but income growth-induced higher demand for medical care is not a bad thing and we certainly need not contain income growth to save on the costs of Medicare. Hence, we are left with relying on changing the structure of health care markets to encourage competition. Such competition has the potential of reducing the current level of expenditures through demand reductions and price competition and at the same time encouraging the development of new technology directed toward cost reduction.

The current Medicare payment system, especially the dominant fee-for-service part, is partly responsible for the very high current level of Medicare costs. Fee-for-service Medicare, combined with supplemental insurance, effectively gives many beneficiaries nearly first dollar coverage. Without real cost sharing requirements in place, beneficiaries tend to have little regard for the price of health care services. When consumers have little regard for the cost of services, we can be certain that the suppliers of services will have little regard for the price they charge. In addition, the benefits of developing cost saving technology are positive only if those who demand services care about cost. Thus, technological changes that increase our ability to find solutions for current conditions for which there are no treatments, will result in higher expenditures. Such expenditures increases will be wholly or partially offset by the development of cost reducing technology with the proper incentives.

We can develop an estimate of the demand effect of introducing a no-first-dollar coverage Medicare system by using the results of the RAND Health Insurance Experiment. The RAND experiment found that a policy with a $500 deductible in 1983 dollars and 100 percent coverage above the deductible reduced total expenditures relative to fee care by 27 percent.[4] Similarly, Christensen and Shinogle (1997) estimated that Medicare beneficiaries who have Medigap coverage used 28 percent more service than do beneficiaries who are not covered.[5] With Medigap, Medicare can be essentially converted to a first dollar coverage policy.

Using results from the RAND study to estimate the expenditures associated with a $2,500 deductible policy results in 24 percent savings. These savings only reflect reductions in demand on the part of consumers. The effects will be even larger as suppliers compete to provide the services consumed under the deductible amount. While switching to a higher deductible policy is seldom mentioned as a Medicare reform, it is instructive to consider designing an insurance package that includes no-first-dollar coverage. Concerns over how lower income retirees will pay for care below the higher deductible can by addressed by providing them with a need-based transfer. The transfer must be designed, similar to a medical savings account, to give them the incentive to consider the cost of care.

BALANCED BUDGET ACT OF 1997

The Medicare+Choice program initiated with the passage of the Balanced Budget Act (BBA) of 1997 was expected to expand the set of private insurers available to Medicare beneficiaries. The act allowed preferred provider and provider sponsored organizations to enter the Medicare market alongside traditional health maintenance organizations. A key difference between the traditional fee-for-service Medicare and Medicare+Choice is the program's payment methods. In the former, providers receive a separate payment for each covered medical service while, in the latter, contracted private plans receive a fixed monthly amount for each beneficiary they

enroll. Competition among the expanded group of providers was expected to reduce expenditures and slow cost growth.

Thus far, evidence supporting the expectations has been mixed at best. According to a recent GAO study, providers participating in Medicare+Choice continue to attract healthier and less costly beneficiaries.[6] Reimbursement rates have, up to this point, been based on a formula adjusted for a participant's geographic location, age, sex, disability status and Medicaid eligibility. Since the reimbursement rates are not individually risk adjusted, providers have the incentive to screen patients and reduce their exposure to high risk patients. The patients who participate in the private plans have a lower cost than the average of patients in fee-for-service, yet Medicare+Choice providers receive the average cost. As a consequence, Medicare+Choice has increased, rather than reduced, Medicare costs.

The BBA required the Department of Health and Human services to develop a risk adjustment methodology that accounts for variation in per capita costs based on health status and demographic factors for payment to Medicare+Choice organizations. In its current form, the adjustment factors are a function of age, sex, Medicaid eligibility, location, and inpatient diagnoses called the Principal In-Patient Diagnostic Cost Group (PIP–DCG). The risk-adjusting methodology improves upon the current methodology but can explain only 6 percent of the total variation in medical expenditures. Other risk-adjustment methodologies are being evaluated, but the GAO study concludes that the new methodology ". . . may ultimately remove less than half of the excess payments caused by favorable selection."[7]

Reimbursing private providers based on preset risk-adjusted reimbursement rates will continue to induce providers to screen patients. This year, reimbursement rates vary by geographic location, age, sex, Medicaid eligibility, disability status and diagnostic cost group. Providers know beforehand how much they will receive for taking on each type of patient rather than being asked to price each of the risk factors themselves. An alternative to having HCFA establish risk-adjusted reimbursement rates is a competitive bidding process in which suppliers bid for each type of patient.

THE RATIONALE OF THE PROPOSED REFORMS

A basic idea behind Medicare+Choice and several Medicare reform proposals on the table are to adopt market-oriented approaches to achieve cost efficiencies. These cost-saving approaches have already been successfully adopted by numerous employer-sponsored health care programs and by the Federal Employees Health Benefits Program (FEHBP). All these programs are designed to make beneficiaries sensitive to the cost implications of choosing a particular plan. The demand side cost-saving incentives will then induce providers to deliver medical services that are cost-efficient. Potentially more important, these same cost-saving incentives will eventually lead to a better balance between service-expanding and cost-saving medical innovations, slowing down the growth of Medicare costs in the long-run.

In order to contain the accelerating costs of Medicare and to optimize its benefit package, we must go even further in modernizing Medicare's payment system by applying market approaches to cost efficiencies. This consensus can be seen from several leading proposals on Medicare reform (including the Breaux-Thomas proposal). In addition to benefit expansion, these proposals include the following payment side changes: (1) Fee-for-service modernization, which would enable the traditional Medicare to act as a prudent purchaser; (2) Medicare+Choice modernization, which would encourage plans to compete on costs as well as quality; (3) A premium support system fashioned after the FEHBP, which would make beneficiaries more sensitive to costs of care.

In the following, however, I want to focus on two other issues related to Medicare's cost problem. First, what is the most sensible way to provide prescription drug coverage for Medicare beneficiaries when costs are currently a paramount concern? Second, I want to argue for the case of prefunding Medicare that takes advantage of the baby boom workers still in working.

THE CASE FOR PRESCRIPTION DRUG COVERAGE

A major purpose of the Medicare program was to offer senior Americans access to medical care. Yet an important part of current medical care, prescription drugs, are for the most part not covered by Medicare. As a result, only about two thirds of Medicare beneficiaries have prescription drug coverage (through employers' plans, Medicaid, Medigap and Medicare+Choice). Thus, while much of the Medicare reform discussion concerns cost containment, another major Medicare updating plan on the table proposes to make structural changes that add out-patient prescription drugs to the Medicare program. For example, the Breaux-Thomas Medicare reform plan (and the earlier Breaux-Frist plan) proposes making coverage available for prescrip-

tion drugs and catastrophic medical costs in a broader Medicare reform package featuring market solutions to cost efficiencies on the payment side. In contrast, the President's Immediate Helping Hand Prescription Drug Plan proposes temporary prescription drug assistance to the neediest seniors until a comprehensive Medicare reform plan including prescription drugs is enacted and implemented.

There are convincing medical and economic reasons for adding prescription drug benefit as part of a reformed Medicare package. Indeed, it is hard to imagine that a modern medical insurance plan does not include outpatient prescription drug coverage as an integral part. Approximately 98 percent of private health insurance plans offer a prescription drug benefit or a cap on out-of-pocket expenses as an integral part of the benefit package. As a result of innovations on drug therapies, prescription drugs have been playing an increasingly important role in health care. According to the Health Care Financing Administration, Office of the Actuary, for the last several years, overall health care expenditures grew at about 5 percent annually while nationwide prescription drug spending grew on average at a much higher 12 percent per year. Prescription drugs as a component of health care are even more important for the elderly due to aging-related chronic diseases. In 1995, as some studies show, an elderly person's total average annual drug costs were $600 compared with $140 for a nonelderly person.[8]

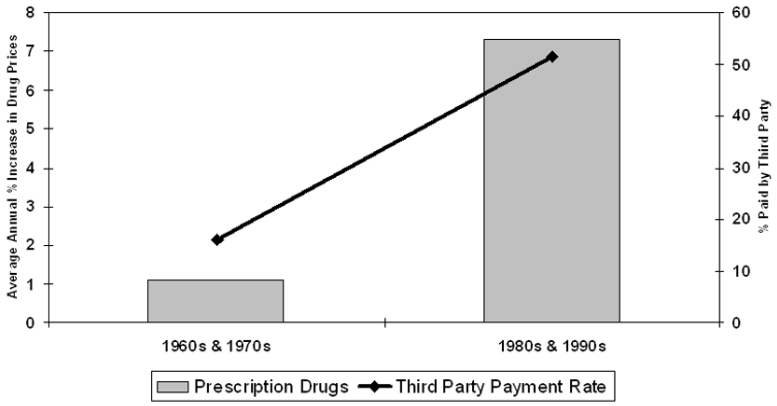
PRESCRIPTION DRUG COVERAGE SHOULD BE BALANCED AGAINST COST CONCERNS

While adding drug coverage to Medicare is important, it raises financing issues to a program whose future funding will strain even optimistic forecasts of future economic growth. At least one study suggests that incorporating outpatient prescription drugs into the Medicare benefit package could add between 7 percent and 13 percent annually to Medicare's total cost.[9] The President's budget proposal for fiscal year 2002 includes $230 billion in expenditures on Medicare and, in addition, the President proposes an Immediate Helping Hand Prescription Drug Plan to offer low-income seniors prescription drug assistance and all seniors catastrophic drug coverage (more than $6,000 in out-of-pocket drug costs) which entails spending $11.2 billion in 2002 and $153 billion in the next 10 years.[10] So even a prescription drug plan targeted only to the neediest would add a significant share (almost 5 percent) to the costs of the traditional Medicare program.

While I believe the new drug benefit initiative featured in the President's IHH plan is carefully crafted to balance competing concerns about the sustainability of Medicare and the hardship faced by some beneficiaries, I do not think a plan providing universal drug coverage with no conditions about other reforms would be a financially responsible policy option. Adding full-scale drug coverage to all Medicare beneficiaries would effectively replace private sector financing with public financing. In 2001, seniors are expected to spend approximately $69 billion dollars on prescription drugs. This amount by itself is equal to 1.3 percent of taxable payroll.

Moreover, as Figure 3 shows, the surge in prescription drug price inflation has coincided with the significant decrease in the share of prescription drug purchases that are paid by individuals. During the 1960's and 1970's, prescription drug prices increased at an annual rate of just over 1 percent while third party payers covered only 16 percent of expenditures. Individuals paid the remaining 86 percent of the cost. For the last two decades the average annual increase in drug prices rose to 7.3 percent, as average third party coverage rates rose to 52 percent. By 1998, third party payers were covering 73 percent of the cost of prescription drugs. Thus, without a comprehensive reform, adding comprehensive drug coverage will likely produce rapidly growing costs.

Figure 3. Prescription Drug Prices and Third Party Coverage



REFORMING MEDICARE'S FINANCING

While most current reform initiatives are aimed at bringing competitive forces to bear on the provision of health insurance for the aged, little attention has been paid to insuring the solvency of Medicare. Over the last few years I have studied the feasibility of prepaying Medicare benefits. Medicare is financed on a pay-as-you-go basis which means that, for the most part, contemporaneous taxes are used to pay benefits. Further, the financing can be thought of as a transfer from the young to the old (including the 75 percent of SMI benefits paid by the Federal Treasury). Thus, the retirement of the baby boomers will cause severe problems for Medicare that are further exacerbated by the possibility that benefits may grow at a faster rate than the growth in the economy, necessitating transfers that grow as a share of the economy.

A detailed presentation of the prepayment proposal can be found elsewhere, so I will briefly outline its main components here.[11] The transition path we have studied is structured as follows. All workers born in 1946 and later would be in the prepaid system and all individuals older than 54 today would remain in traditional Medicare. Beginning today, individuals in the prepaid system would establish and fund a health insurance retirement account that at retirement would be sufficient to purchase health insurance for the rest of their lives. This may seem a tall task, and indeed it is, but it is important to initiate the transition now and take advantage of the earning power of the baby boomers while they are workers, rather than waiting until it is too late, when they become retirees and begin to draw benefits.

In Table 1, I present the lifetime contribution rate on labor earnings required to prepay Medicare benefits assuming that per capita benefits grow at the rate of GDP per capita growth + 1 percent.[12] I present the rates required of new labor force entrants to prepay Medicare benefits and those required to prepay a $2500 deductible policy. Recall that the prepaid program is phased in for individuals born after 1945, so any move to a higher deductible policy would not affect current or near term retirees. As the rates in the table indicate, prepaying the total Medicare package can be prepaid at rates that are less than the current payroll tax for the HI program by itself. At a 5.4 percent real rate of return, the contribution rate is 2.68 percent and if the rate of return is 8.5 percent the contribution rate is 0.86 percent. In the following simulation, we allow the rate of return to decline as the accumulated funds in the health insurance accounts increase the nation's means of production. The 5.4 percent return is roughly the long run return on a portfolio comprised of 60 percent stocks and 40 percent bonds. The higher 8.5 percent return is the pretax rate of return on nonfinancial corporate capital.[13] This rate is the marginal product of capital and reflects the rate realized on the accounts if all taxes are waved. The lower rate of 5.4 percent is after corporate tax payments. In the simulation results,

I use the pretax rate and implicitly assume that all taxes are waved on these accounts.

We introduce the higher deductible policy to show the level shift in the cost of insurance. The lower cost is due to demand responses exclusively, even though as consumers face the full cost of care below the deductible, suppliers will compete for those first dollars resulting in lower prices. We estimate that contribution rates necessary to prepay the higher deductible policy are 2.27 percent and 0.73 percent, at the 5.4 percent and 8.5 percent real rates of return, respectively.

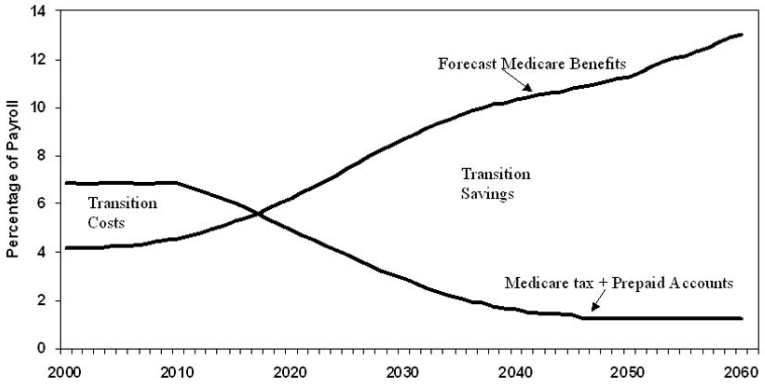
The Table 1 shows that the contribution rates for new entrants are low. However, the rates escalate for individuals who have fewer years remaining in the labor force. In the simulation path we have studied, workers pay for contributions to individual accounts for all individuals in the new system and for the Medicare costs of current and near term retirees. In each year the transition tax rate, or tax in excess of the rate that would be necessary without prepayment, is the same for all workers.

Before turning to the simulation results I would like to point out a few favorable consequences of prepaying retirement medical insurance. The first I have already mentioned in passing is; prepayment increases the nation's capital stock. It can be shown that pay-as-you-go transfers reduce savings and the size of a nation's capital stock or means of production. With prepayment, that outcome is reversed; capital stock rises and so does income. The second consequence is that prepayment mollifies the effects of variations in generation size. Without prepayment, the baby boomer's retirement will result in a great burden on the taxpayers, necessitating high tax rates which have severe incentive effects. The final consequence is related to the higher tax rates. By prepaying benefits, future payroll taxes will be reduced, producing significant efficiency gains.

Table 2 presents the simulation results. The first column shows the status quo Medicare tax rate. The rate is the ratio of Medicare expenses for the aged net of benefit payments divided by taxable payroll. We use taxable payroll as the denominator as an accounting metric, realizing that SMI is not financed by a payroll tax. This column shows the tax rate assuming no prepayment. The remainder of the table shows the results with prepayment. The initial marginal productivity of capital is assumed to be 8.5 percent . Contributions to the individual account are assumed to increase the capital stock dollar for dollar. As the capital stock rises, the marginal product of capital falls and wages rise.

The higher wage base is used as the denominator in the next column titled forecast Medicare costs. The higher wage base results in lower tax rates. The next column shows the benefits paid from the prepaid accounts. The first of the baby boomers retires in 2011, so the prepaid benefits are zero until then. As individuals with prepaid insurance comprise an increasing share of retirees, their share of total benefit payments rise. By 2050 all of the benefits are paid from the prepaid accounts. The next column identifies the share of benefits that must be paid by tax revenues. These are the benefits of those who are born before 1946. As the column indicates, by 2050 these individuals have died and the tax requirement is eliminated. The aggregate prepaid account contributions are shown in the next column. Because the transition path being analyzed requires that all individuals born in 1946 and later have prepaid accounts by the time of their retirement, the aggregate contributions are well above the rates shown in Table 1 for new labor force entrants. Further, the long run rate of 1.24 percent is above the 0.86 percent rate in Table 1 because of the decline in the rate of return earned on the accounts. The next column shows the transition cost. These costs are the taxes in excess of the taxes with no prepayment. Until 2018 the total cost of the transition, presented in the last column, exceeds the cost of the pay-as-you-go system. Figure 4 graphically depicts the forecast Medicare costs and the Medicare tax plus prepaid account contributions. For the first 18 years the transition is more expensive than continuing with the current financing arrangement. Thereafter, the prepaid system is less expensive.

Figure 4. Transition Costs and Benefits



Author's estimates of HI and SMI expenditures assuming that the long run per beneficiary expenditure growth rate is equal to per capita GDP growth plus 1 percent based on the recommendation of the technical review panel. SMI expenditures are net of premium payments. Analysis is limited to beneficiaries 65 and above. See Table 1 for details.

CONCLUDING REMARKS

In order to contain the accelerating costs of Medicare, Medicare's payment system can be modified by applying market approaches to cost containment that have been successfully tested by numerous employer-sponsored health care programs and by the Federal Employees Health Benefits Program. Consideration of prescription drug coverage should be balanced against this heightened cost concern. Besides reforming delivery of care, the rising cost pressures also makes a strong case for prepaying Medicare.

TABLE 1.—LIFETIME CONTRIBUTION RATES AS A PERCENTAGE OF TAXABLE EARNINGS FOR LABOR FORCE ENTRANTS

Real rate of return	Medicare replacement	$2,500 deductible policy
5.4	2.68	2.27
8.5	0.86	0.73

TABLE 2.—SIMULATED TRANSITION TO PREPAID MEDICARE

Year	Status quo Medicare tax rate	Forecast Medicare costs	Benefits paid from prepaid accounts	Benefits paid from tax revenues	Aggregate prepaid account contributions	Transition cost	Medicare tax plus prepaid accounts
2000	4.17	4.17	0.00	4.17	2.71	2.71	6.87
2010	4.66	4.58	0.00	4.58	2.30	2.30	6.87
2020	6.45	6.22	2.94	3.28	1.63	0.00	4.91
2030	9.14	8.70	7.12	1.58	1.31	0.00	2.90
2040	10.88	10.30	9.94	0.36	1.25	0.00	1.61
2050	11.90	11.25	11.25	0.00	1.24	0.00	1.24
2060	13.77	13.05	13.05	0.00	1.24	0.00	1.24
2070	15.91	15.28	15.28	0.00	1.24	0.00	1.24

ENDNOTES

1. This growth assumption was one of the primary recommendations published in Review of Assumptions and Methods of the Medicare Trustees Report: Financial

Projections, December 2000. My estimates are not adjusted for the age distribution of Medicare enrollees.

2. Paying Social Security benefits to the elderly and to survivors in 2040 will cost 15.5 percent of taxable payroll. Combined with Medicare the costs will climb to 27.7 percent of payroll.

3. On a related matter, faster introduction of young immigrants to this country may offer some help on the revenue side, but as some studies show, the scale of immigration that may generate a significant impact on Medicare and Social Security's financing is likely to be politically infeasible.

4. See The Demand for Episodes of Medical Treatment in the Health Insurance Experiment, Emmit B. Keeler, Joan L. Buchanan, John E. Rolph, Janet M. Hanley, and David M. Reboussin, 1988, RAND Health Insurance Experiment Series.

5. "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," Sandra Christensen and Judy Shinogle, Health Care Financing Review, Fall 1997, pp. 5–17.

6. Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending, August 2000, GAO/HEHS–00–161, General Accounting Office.

7. GAO, p. 5.

8. The first number is from M. Davis et al., "Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries," Health Affairs, Vol. 19, No. 1, 1999 and the second number is from Agency for Health Care Policy and Research Center for Cost and Financing Studies, National Medical Expenditure Survey Data, Trends in Personal Health Care Expenditures, Health Insurance, and Payment Sources, Community-Based Population, 1987–1995 (March 1997). *http://www.meps.ahcpr.gov/nmes/papers/trends/intnet4d.pdf*

9. M.E. Gluck, National Academy of Social Insurance Medicare Brief: A Medicare Prescription Drug Benefit (April 1999). *http://www.nasi.org/Medicare/Briefs/medbr1.htm.*

10. According to the President's IHH drug plan, Seniors whose incomes are at or below 135 percent of poverty would have no premium and nominal co-payments for prescription drugs. Seniors whose incomes are between 135 percent and 175 percent of poverty ($15,000 for a single person) would receive partial drug coverage.

11. See the Economics of Medicare Reform, Rettenmaier and Saving, The Upjohn Institute for Employment Research, 2000, for a complete discussion of the proposal and for details of our methods.

12. These results are based on a simulation model we developed several years ago. The growth rate assumption is relative to our projection of GDP. Medicare benefits are net of SMI premium payments.

13. This rate is from James Poterba, "The Rate of Return to Corporate Capital and Factor Shares: New Estimates Using Revised National Income Accounts and Capital Stock Data," NBER working paper no. 6263, 1999.

Mr. PUTNAM. Thank you, Dr. Saving.

Are there questions of the witnesses?

Mr. Gutknecht.

Mr. GUTKNECHT. Thank you, Mr. Chairman, and I want to thank the distinguished panel for coming here today.

I would like to, first of all, tell a quick story. When I was in the State legislature, I remember I was on the subcommittee that dealt with the public employees' benefits.

I remember just a number of years ago that there were some experts who came in one day, and they were so excited. They had a new idea for the health insurance program for the State employees.

It was going to involve first dollar coverage. It was going to save us all kinds of money, because people would go in early, they would get treated faster, and it was going to save us money.

I remember that day. I am not an economist, and it certainly is not an economist's term; but I said, there is unlimited demand for free stuff. I said, I do not really see how this is going to save us money.

About a year later, those same people came scurrying back into the same room saying, we have got to make a change here. This thing is eating us out of house and home.

I am concerned about that. I think, Dr. Saving, your chart here on prescription drugs is a very good one. I do think that part of what is driving the inflation in the prescription drug industry is the fact that an awful lot of Americans have some kind of prescription drug coverage, and do not really know how much prescription drugs cost.

I say that, even with my parents. We were talking about this last year. I asked them how much they were paying for prescription drugs. They said, "I think it is $4." They really did not know how much. They do not take that many drugs, but they were somewhat divorced from that.

Dr. Wilensky, I came in late, and I am sorry, because I really wanted to hear all of what you had to say. You mentioned at least a little bit about prescription drugs. I think you said, and I do not want to put words in your mouth, but I think you said that we should be very wary of another BBA type fix, until we get real reform, structural reform, of the system, and I agree with you.

Dr. WILENSKY. I did say that.

Mr. GUTKNECHT. Did you mention prescription drugs?

Dr. WILENSKY. What I said is, two strong recommendations. We need prescription drugs, but we need to have that done within the context of overall Medicare reform.

I recommend not doing a standalone. Let us start with prescription drugs and get to reform when we get to it, I think, because of the financial fragility of the program, and the obvious ease with which it is to give benefits, relative to doing the kinds of other changes that are needed.

So my two recommendations are these. Do prescription drugs, but only in the context of overall reform. If the Congress does not do prescription drugs and/or Medicare reform, do not use the money that has been set aside in the budget to increase provider payments.

There was a rationale for the first two rounds, post-PBIA. But I think unless there is some clear problem that is not currently obvious, that should not be repeated.

Mr. GUTKNECHT. Well, I really want to come back to this, because it does strike me that if we go with some kind of a new entitlement for prescription drugs, particularly under the current system that we have right now, with the patent situation, with the FDA, and so forth, this is an issue that I have learned more and more about, and the more I learn about it, the more troubled I am.

I do not believe in price controls, but I do believe in free markets. We, in the United States, are really caught in a very difficult bind, as it relates to prescription drugs. That is that American consumers, those who are paying the full freight right now, are paying much, much more than any other consumer in the rest of the world, as far as I can determine.

I really do think that we have got to look at ways that we can at least allow for more competition, even within the prescription drug industry. Frankly, we have got to get the doctors to participate in this.

You know, in some respects, I believe they are part of the problem, because they have a tendency to want to prescribe the best for

their patients, and I am not questioning their motives. But the net effect of this sometimes is to really make this problem even worse.

The other problem that I was surprised to learn, and I do not think most Members of Congress know this, is that in terms of the generics, there really is not much difference between a generic drug and a brand name drug.

As a matter of fact, I am told, and maybe you can correct me on this, that the difference between most generic drugs and the brand name drug is no different than one batch of the brand name drug and the next batch of that same brand name drug.

Yet, in many, many cases, we could save countless numbers of millions of dollars, if we could simply get the doctors at least to consider more often prescribing the generic brand.

But I do think the other part of it is, we have got to get at this price thing. You know, with the pharmaceutical industry, I am not out to get them. But on the other hand, in many respects, it certainly seems as it relates to American consumers, they have a license to steal.

When you take commonly prescribed drugs that are selling for 10 percent of what we sell them for in the United States, in Europe, it really amounts to the fact that American consumers are subsidizing the starving Swiss. At some point, I think we have to say, we are not going to play that game any longer.

Is there any comment on what we can do to create more competition, and help hold down the price of drugs? This is a great chart. I love this chart. I am going to steal it from you, and use it in some of my special orders.

Dr. WILENSKY. Let me give you one suggestion with an issue that you raised initially, which has to do with intellectual property protection.

As a result of a number of pieces of legislation that were passed by the Congress in the last 16 or 17 years, there has been an almost effective doubling of the amount of time, on average, that a new chemical entity is patented.

While I think we need to be careful to protect intellectual property, I am not suggesting that you do away with it. The series of changes have substantially increased the amount of monopoly control and power that exists. I think it may be time to go back and to see the effect that has occurred over the last 16 years, and to try to make sure that we have the right balance.

Whether or not generics are substantially less, whether there is competition with other branded names varies very much by the type of compound. But you are clearly correct, we want to encourage competition. That means making sure that the monopoly power that is granted by the Government for particular new elements is the good tradeoff. We want the best tradeoff that we can have, and I think that is important.

Secondly, you might need to help make sure that information is available, so that both physicians and patients understand when some of the new, more expensive compounds really provided added value.

Information, of course, will not be enough. They need information, and you need to have economic incentives that encourage individuals, and through them, the physicians that they go to for serv-

ice, to make sure that their economic incentives support appropriate use of new therapeutics.

But I do think that reviewing intellectual property protection provisions is something that is probably ripe for Congress to consider.

Dr. MOON. Could I just underscore what Gail has said, at the end, in particular?

If we consider expanding prescription drug coverage to this population, the amount that it would take in additional funds to provide good, credible information to consumers would be rounding error.

Consumers now only get their information from research largely funded by drug companies. They are, understandably, a little suspicious sometimes, when they hear certain kinds of information, or else accept unreliable information.

What would be helpful, not only for Medicare, but for the private sector as a whole, would be good information, available from an independent entity, about when generics are totally safe and equivalent, and when they are not; when drugs within a particular class that are still under patent are largely equivalent or not. You might actually get some price competition, which is unheard of, across brand names, if you did that.

All of the drug proposals that people are talking about usually have a 50 percent co-pay. Beneficiaries will be very well aware of the cost of drugs, as many of them already are.

Dr. SAVING. It is kind of interesting here, because I gave a speech on Friday in Dallas to the Chamber of Commerce. I was driving up there from College Station. I saw a lot of billboards. The billboards were advertising Lasik surgery. The biggest number on the billboard was the price.

Now if you open up any magazine, and you will see ads for pharmaceuticals. Nowhere in that ad is the price mentioned. There is a reason for that. That is that the people buying it are not paying, and they do not care what it costs.

If we can make people care what it costs, the drug companies are going to do a lot of this information for us. They are going to tell us what the price is. That is the kind of competition that we would like to see.

We would like to see them doing what they do with Lasik surgery: advertise the price; tell us what the drug is going to cost; why we ought to be buying it instead of another one; and what its price is going to be.

Mr. GUTKNECHT. Mr. Chairman, can I follow up?

Mr. PUTNAM. You certainly may.

Mr. GUTKNECHT. I am not really in favor of restricting advertising, although it does bother me, all the pharmaceutical ads that we see on television, today.

You have just raised a very good point, what about the idea of saying, OK, you can go ahead and advertise all you want, but you have got to put the price in there? I mean, you do not have to necessarily respond, but it is something we maybe should think about.

Dr. WILENSKY. It is a very interesting idea to try to force the information. Again, I think you need two components. To get better information will help, but it will not be enough. But it is a very interesting idea, as the first step.

Mr. PUTNAM. In fact, grocery store ads or drug store ads advertise nonprescription drug prices all the time.

Dr. WILENSKY. Right.

Mr. PUTNAM. It is really the prescription system that makes this difficult. It is this deal between the doctors and drug companies that makes the price information less important. We need to break that, so that the drug stores who are advertising big, full-page ads in the newspaper are going to talk to us about the price of prescription drugs. But that will only happen if the buyers care what it costs.

Further questions; Mr. Collins.

Mr. COLLINS. Many of our seniors under Medicare or Medicaid take a sizable number of drugs, maybe five or six, and some even eight or nine.

What do you think or what is your opinion of the consultant pharmacies who analyze how one drug may offset another drug, and come back with recommendations that oftentimes lead to a fewer number of drugs being taken?

Dr. WILENSKY. Well, the pharmacies and the pharmacists can provide important information to the extent that they are the single supplier of prescription drugs.

One of the advantages in coordinated care/managed care plans is, there usually is somebody around who is looking at all of the therapeutics that are being prescribed.

A pharmacist can provide that very important service. It really will vary in the community as to how likely the same person is to be providing that kind of information, or whether or not the information systems are connected.

So there is an important service, in terms of whether there may be a drug interaction with regard to other things known about the individual. Whether or not the senior is likely to go to the same pharmacy for all of their prescriptions is a more complicated issue.

Mr. COLLINS. Let me narrow it down a little differently, a little closer. In the nursing home, where a resident may, as I say, be taking a half a dozen different drugs, there is a consultant pharmacist, who will go into the nursing home and look at all the drugs that that nursing home is responsible for administering to that resident. Are you familiar with that program, and what is your opinion of that?

Dr. WILENSKY. I think when you have individuals who are receiving, and by the nature of being in a nursing home, you are having individuals with multiple dependencies, and that is typically why they are there, and they will be taking substantial numbers of pharmaceuticals.

I am a trustee for the United Mine Workers Health and Retirement Fund, that funds the retiree benefits for individuals who average 80 years old. They tend to be a very old, frail population. They have very high pharmaceutical prescription drug use.

As part of that program, they have brought in one of these pharmacy benefit management groups to try to work with the physicians and gerontologists to make sure the very high users are getting proper guidance, both to the physicians and to the individuals.

I think that will mean to be careful about whether or not it would make sense to think about this, in general, on an average,

for seniors; or whether there might be some special services for individuals who have extraordinary numbers of prescription drugs, who have catastrophic expenditures, to think about whether people who are in that category might need or benefit from some kind of case management, clinical guidance, however you want to call it, and who the right person will be. But I think the point that you are raising is a good one.

I think the issue of who the right person will be is very important. One of my concerns is that sometimes in nursing homes, the nursing home pushes for certain kinds of medications to make the patients easier to take care of, to deal with incontinence, and that can cause problems, in other areas, for example.

So one of the things that you also want to make sure is that when you are dealing with something like a nursing home, that it is not someone affiliated with a nursing home, who then is inappropriately coordinating certain kinds of drugs that may actually be harmful to the patient.

One of the difficulties with any kind of program is that you would like to have good oversight, and make sure that people get good care, which is another reason why I think having some independent group that would have recommendations, could have some oversight authority, and could collect the information to provide it to individuals to say, you should be aware and worry about this kind of drug interaction.

Mr. COLLINS. I caught the tail end of a news report the other day, and I have not been able to track it down. There was some study just recently that indicated that there was quite a duplication in medication, which added quite a bit to the cost. So that is where I was coming from.

Dr. WILENSKY. This also causes clinical problems, as well, for individuals who have direct drug interactions; particularly for individuals who take a lot of pharmaceuticals, or who have a lot of complicating illnesses.

Mr. COLLINS. I thank each of you for being here today.

Thank you, Mr. Chairman.

Mr. PUTNAM. Thank you, Mr. Collins.

Mr. Kirk.

Mr. KIRK. Thank you, Mr. Chairman.

Dr. Wilensky, you are highly experienced in all things HCFA. I am wondering if you could tell me if there is an automatic and associated cost with removing the reimbursement rates under Medicare, that are currently calculated on a county by county basis? If we went to MSAs, does that necessarily cost us anything?

Dr. WILENSKY. It would not necessarily cost you anything. You could have a budget-neutral calculation, that would have the Federal Government spending exactly as it spends now.

Mr. KIRK. For you, and I ask you more as an outside witness, as a political judgment, is that possible to do?

Dr. WILENSKY. It is possible. We have just been struggling with this on the Medicare Payment Advisory Commission. Let me tell you our recommendation and why.

We have been uneasy in urban areas about going to an MSA, because we think that the counties may have some substantial differences of what may be five or six counties within an MSA. There

are tradeoffs of getting into the larger unit; but on balance, the Commissioners decided against it.

Where we do recommend going to a larger grouping than now exists is for the rural or small urban areas, where we think the current configuration provides unstable estimates, and estimates that vary in ways that do not make much sense.

So our recommendation is that the Secretary consider larger groupings that would provide stable estimates of spending in the non-heavily urbanized areas; but on balance, to stay with the county for the urban areas.

However, we recognize that there are tradeoffs that you get into. You will then have reimbursements differ, in terms of adjacent areas.

Mr. KIRK. I represent a community that is all above suburban Chicago. The communities 20 miles north of the county line are just as suburbanized as those below.

What you are saying is, you recommended against solving that problem. Right now, health care is radically different on one side of road, in a community that is no different than the lower part.

Dr. WILENSKY. Also, we had recommended that in instances where there is reclassification, which has been used to try to smooth out some of the differences, that it be done in a way that recognizes it does not leave whatever is left behind in the areas around that reclassified hospital, et cetera, that they not be hurt by that. So we think that there are ways, if there are particular problems that exist, for a hospital in an adjacent area.

I do not want to say that there are problems that we do not solve. We think, on the other hand, we will take an area, and pretend as though the four or five different areas within the metropolitan area, and we happen to be now in Washington, in an area that is a five county MSA. There really are some substantial differences in the five counties that make up the Washington MSA.

So you need to decide which way you think you solve more problems than you create.

Mr. KIRK. Right, and I would just say, in Chicago's case, in the difference between Cook and Lake County, Chicago has long ago broken out of the bounds of Cook County. I have now got census projections of 350,000 people moving the Lake County.

So this is only going to get worse. I think we need to address the large groupings, because right now, you have got Medicare recipients in communities that are identical, who are treated differently.

Dr. WILENSKY. Are you talking about treated for purposes of HMOs, or in terms of how the institutions are reimbursed?

Mr. KIRK. HMOs.

Dr. WILENSKY. Well, that really raises a somewhat different issue. Let me try to be clear. Certainly, Mr. Nussle is not here now, but Iowa is a State that is affected by this.

We are very aware of the different premium payments that occur to HMOs, as a result of Medicare, the Medicare Plus Choice payments. We tend to ignore, all of us, that spending on behalf of the senior, under traditional Medicare, which is where 87 percent of the seniors are, varies even more now than the HMO payments vary. But we do not tend to think we should do anything about that. That is why we get these variations in HMO payments.

Now the Congress has gone in and set various floors that do not let the payments fall as low as they do in some of the urban and low-cost counties.

I misunderstood the question that you were asking me. We have a real problem in Medicare, in that it is a national program, but spending by the Government on behalf of seniors varies all over the map. A lot of it has nothing to do with either the health of the senior or the cost of providing health care services. It has to do with how health care is provided and how health is demanded.

If we want to seriously look at that issue, which I would encourage the Congress to do, we need to think about the variation that occurs in traditional Medicare spending, and think about how we want to try to affect those kinds of variations.

To only look at what goes on in the Medicare Plus Choice plan is to focus all our concern for 13 percent of the population, when exactly the same problem is going on for the 87 percent in traditional Medicare.

Again, if these are areas where you would like to have any additional discussions with myself or staff at Medpak, we would be glad to share with you some of our thoughts.

Mr. KIRK. I absolutely need that, because I will tell you, it is a burning issue in the 10th District of Illinois.

I have one last question for Dr. Saving. This is on your assumption of Medicare, your famous Figure 1 here. Is it at all reasonable to assume that the expenditure growth rate will be GDP plus one?

Dr. SAVING. Yes, I think it probably is, as a matter of fact. It is based, if we were using economics terms, on the fact that health care, especially for the elderly, is a superior good. What a superior good is, it is good; where when their income goes up, they spend a greater share of their income on it.

Now you ought to note that that does not mean that they are spending less on other things. It just means they are spending a smaller proportion of their income on other things.

So it is not the case, assuming that it is going to go up 1 percent greater than GDP, that it means that it will, at some point, in some limit, be all of GDP, because it will not be.

Mr. KIRK. Right.

Dr. SAVING. It will never be all of GDP. Everything else is also growing.

Mr. KIRK. It would seem to me, a more dynamic model would make sense; since the previous year's growth was 4.7 percent, that this would level out over time, as we get into a higher percentage point, rather than just be at a straight 1 percent growth, which has an enormous impact on the general revenue demands that Medicare has.

Dr. SAVING. Well, the revenue part does not have any impact on the cost part, yes.

Mr. KIRK. Right.

Dr. SAVING. But if it is true in health care and it appears to be the case, and of course, some of that is probably driven by the institution that we have set up, which encourages the research to be not cost-reducing, but to be new technique developing, because that is where the money is.

If you are going to develop new techniques, then we are going to find new ways to replace all our body parts that are wearing out, and that is really where this is coming from.

What I have done here is simply take the technical panel, and I have read the technical report, and I agree with them that health care, at this point, is a superior good. Your question really is, are we ever going to have technology that is going to change this? That may be the case, and it may happen if we change the institution.

But the current institution simply ensures that the technological developments are going to be ones that are going to increase expenditures.

The technical panel really based their recommendation on that fact. They are saying, there is nothing in the offing that is going to change that.

Mr. KIRK. Thank you, Mr. Chairman.

Mr. PUTNAM. Thank you, Mr. Kirk. I especially appreciate your questions on the inequities of reimbursement rates, because it is a burning issue in the 12th District of Florida, as well.

The gentleman from Kentucky, Mr. Fletcher.

Mr. FLETCHER. Thank you, Mr. Chairman, and thank you all.

We have had several committee hearings going on at the same time. We are dealing with education, so forgive me for not getting in earlier, but thank you for coming and for your presentation.

Dr. Wilensky, I wanted to ask you a few things. First off, I want to thank you for all the work you have done in the past, your expertise.

Dr. WILENSKY. You are welcome.

Mr. FLETCHER. I have been able to visit with you at several conferences. Anywhere there are experts on health care, you seem to show up. So thank you for all the work you have done.

I understand that on your testimony here, that you support the reform model after the Federal Employee Health Benefit Plan. Let me ask you under that, if you would describe the similarities between the Bush Medicare reform proposal and what benefits we receive, as Members of Congress.

Dr. WILENSKY. Well, the administration has not come forward with the proposal that they will make the Congress for long-term reform.

What I have done is to take what was part of the campaign, where there was more detail in the proposal that was in the campaign, and also the principles that are part of the budget that was just submitted, and to indicate that they are consistent with that.

So without wanting to tie the administration's hands in terms of what they will be submitting, they idea would be to have a choice of health care plans available to seniors, as is the case under the Federal Employees Health Care Plan.

I certainly presume that traditional Medicare will continue to be a part of the offerings that are there. What will be important is to make sure that, unlike the Federal Employees Health Care Plan, where there is no risk adjustment, it is important to have risk adjustment for seniors.

It is not that the problem is not present for the under 65, but both the absolute level is so much higher, and the likelihood of tor-

pedoing plans, if there is not risk adjustment, is greater in terms of the Medicare Plus Choice plans.

A lot of technical issues about how to try to make sure, particularly in the short term, as we are deciding exactly how to do risk adjustment, and whether or not to do some partial capitation or other strategies, that reduce some of the financial risk, to protect some of the frailest seniors that are around.

But like the Federal employees, there would be an annual enrollment. Like the Federal employees, information would be provided by the Government. Presumably like the Federal employees, there would be a cottage industry that develops, that provides even better information about what to expect from plans, given certain kinds of health patterns.

It would allow seniors to have choices between the traditional Medicare and other kinds of health care plans. It would be a fundamentally different dynamic than exists now, because the contribution made by the Federal Government, by Medicare, in terms of the dollars to cover the premiums, would not vary with the cost of the plan.

That is generally the distinguishing characteristic of the Federal Employees Health Care Plan. It is what changes the whole economic dynamics over what exists today.

While I think there are a lot tinkerings that you could do, that the Congress could do, in terms of applying this principle to Medicare, it is the notion of having the amount contributed by the Government vary by house status or by age or by cost of living index; but not by the cost of the health care plan that the individual chooses. That is really what drives the different behavior.

Mr. FLETCHER. You were discussing earlier, from one of the questions, the disparity that exists between different regions and the AAPPCs, and particularly Medicare Plus Choice. You are saying that that value, I assume, was actually derived from probably expenditures that were done in those regions.

Dr. WILENSKY. Exactly.

Mr. FLETCHER. Yet, I am not sure that any studies show that the health care in those regions, or when you are looking at the experience rating in those, as far as matching demographically that the care or morbidity mortality is much higher in folks that are using a lot less money.

What kind of disparity do we have on private insurance, related to Medicare, in a regional way? Does it correlate with that? Is it a practice, just among geriatrics?

Dr. WILENSKY. No, this is an area, a term of art that you may have heard, called variations in practice style. Dartmouth puts out an atlas, if you want to see how large these variations are, in how health care is delivered, and how medicine is practiced.

There was an article in the Wall Street Journal a while ago, indicating the very high likelihood of an individual having a bypass procedure, or having other procedures, in some particular counties, and I think it was in Texas, relative to other areas, which appear to have people who looked very similar, in terms of their health and age profiles.

It is a phenomenon that we have known existed, and probably we have known about it for the last 30 years. There seem to be

very different ways of practicing medicine. It has to do with the individual that is doing the practice, and not the health status of the patient.

It has to do with uncertainty about the symptoms and about the right procedures, given the symptoms. It is an issue that exists in the under 65 and the over 65, and exists in the Medicare population, as well as others. So it is something we know about.

Mr. FLETCHER. I think it brings this up, as efforts have been made to try to level the disparities between different regions, that it really is going to have to get back probably to the practice of making sure that we are using best guidelines or whatever.

Let me ask you, as we are running out of time here, one question. Given the institute of medicine reports on quality, and the fact that reimbursal does not allow providers much venture capital to invest in the information technology, and you need to really go more digital in medicine, what recommendations would you have, and are there some things we can do to begin in that direction, because we really, compared to other industries, are pretty archaic?

Dr. WILENSKY. I think there are a couple of things that could be done. The first is, I am not convinced that the medical profession, the people leading many of the hospitals and other institutions really believe that high quality costs less. We hear that, as a general dictum.

But when you look at how money is invested, it is not clear that either we know how to do that, or that they believe what is generally, in other sectors, to be true. One of the real questions is, is it not convincing; why does this not happen? There does seem to be a disconnect.

In some of the payments, it may be that how the payments are made are too prescribed in terms of what they can be used for. That is clearly not in anybody's interest.

Making sure that there is information available about what works and how it works, and why this is important, I think, is an important part.

But getting the patients to demand the kind of information that they should be demanding, as smarter patients and consumers, to recognize that these are issues that they ought to be concerned about as patients, is important.

Having reports like the Institute of Medicine make it clear how sophisticated health care is, in some aspects, in terms of what we do to people in terms of procedures, and how unsophisticated health care is, in other aspects, in terms of making use of the information and technology; and putting in place the kind of fail-safe procedures that are so much a part of the airlines, or so much a part of other sections has not happened.

Trying to help get that structure in place is certainly something that the Congress, working with groups like the Institute of Medicine, could help foster.

Mr. FLETCHER. Thank you, Dr. Wilensky.

Mr. PUTNAM. Thank you, Mr. Fletcher. Before you have to run off, I need to get your consent that all members have seven legislative days to submit written statements to be printed in the record. Do you object?

Mr. FLETCHER. I have no objection.

Mr. PUTNAM. Thank you, sir.

Let me ask two questions and then we will wrap this up. According to a recent survey, 46 percent of the Nation's uninsured have incomes above 200 percent of poverty level.

Knowing that, to what extent will health care credits to the poor really affect the number of uninsured in this country?

Dr. WILENSKY. It depends how the health care credit is structured. I think the refundable tax credits that we have talked about for health care, that the President had proposed during the campaign, and we will see whether that is exactly the structure of what is proposed to the Congress will very much help the low middle income people; those, say, at 150 percent of the poverty line, 200 percent of the poverty line, and above.

Whether or not the kind of refundable credits that have been discussed, at least in the past, will help those below the poverty line, who are about one-third of the poor, is a different issue.

Recognizing that there are differences in those who are uninsured, they are a section that are very poor, a group that are low middle income; then, as you said, almost half that are close to the median family income in the United States that is about 200 percent of the poverty line, these are individuals who might be much more susceptible, if they are to buy insurance, if they are provided some tax subsidies.

If you only limit your help to people who are poor, below the poverty line, or just above the poverty line, obviously, there will be substantial numbers of people, who will not get any assistance.

Mr. PUTNAM. Dr. Moon.

Dr. MOON. I also believe that for low income individuals, it may not be the best policy to provide refundable tax credits. There are many problems that arise concerning when you give them the refund: do they get it right away; do they get it beforehand? Is there a reconciliation that occurs at the end of the year, if their income goes up, so that they have to pay money back?

There are a lot of problems when you are dealing with a vulnerable low income population, that suggests to me that tax credits may not be the way to go.

Tax credits would be more helpful for the people at 200 percent of poverty and above, rather than the other way around.

Dr. SAVING. I agree mainly, I think, with Gail, and that is that it is going to help people well below the 200 percent level.

But the other issue is to understand why a number of people are uninsured. A lot of the uninsured have to do with the fact that we are pricing insurance not risk-adjusted properly, and these are younger people, on the average. Younger people are healthier people.

If they are going to have to pay, for example, like a single male, who is going to have to pay for health insurance that covers pregnancy, he is not likely to get pregnant. He is going to have to pay for that insurance. He is going to subsidize the older people like me. To the extent that he wants to pay that subsidy, it is too big a subsidy.

If insurance were priced totally risk-adjusted, I think we would see far fewer people uninsured. Catastrophic insurance is all we really care about anyway, for these people, probably. They should

have that. If it were totally risk-adjusted, it would be very inexpensive.

I think these tax credits go a way toward doing that. But I think you would want to take away, probably, the tax benefit that firms get, or that people who work at firms get. You actually would want to give them this refundable tax credit, but also charge off the insurance that their firm gives them, and make that ordinary income.

Now that would allow outside insurance to compete with the firms operating on their own insurance. I suspect, though, that that system would very quickly take the firms out of the insurance business; because right now, they are self-insuring, and basically farming out the paperwork to insurance companies. They farm out the paperwork, and they would get out of the insurance business.

Then, health insurance would be portable, instead of what we now have. It would be like automobile insurance. I think that is a far superior thing to what we are doing. We are probably going to move in that direction.

But with these tax credits, and then the combination of that and taking the health care benefit that firms give, and declaring it to be ordinary income to workers, at that point, they get the tax credit back by either buying health insurance from their firm, or buying it outside; but they get the same impact.

So there is no benefit to buying it from the firm, particularly. I think we can change the whole industry in that way.

Mr. PUTNAM. Thank you. I would also ask for your observations on community health centers, and what impact they have on helping to address a certain demographic population, and reduce the number of uninsured, or reaching the needs of those who may be uninsured.

Dr. WILENSKY. If I may, I would like to respond to that. I think that doubling the number of people served by community health centers, and making a substantial investment in their structures is a very good addition to the infrastructure, particularly if it results in coordination with the hospitals and academic health centers, or secondary and tertiary hospitals, that these individuals will receive.

Texas has done that. The University of Texas system has worked with the community health centers. What it means is that individuals going from primary care, that they are received in the community health centers, into the hospital, and then back to the primary health care center, and have their records go back and forth with them.

We need to recognize that in many parts of this country, particularly in areas that have large rural areas, very low population density areas, that there may be some difficulty in building the kind of health infrastructure that exists elsewhere. For some individuals, having an insurance card, per se, may not be enough.

This is a way, both because there will remain people without insurance coverage, and because, for at least periods of time, there is unlikely to be the facilities and individuals available in some parts of the country, that investments in community health centers can be very helpful. But they do need to have coordination with where the individuals receive secondary and tertiary care. Other-

wise, the fragmentation can result in both more spending and less good health care than we could have.

So I think it is a promising way to go, and I hope that the Congress gives it favorable consideration.

Mr. PUTNAM. Dr. Moon.

Dr. MOON. Community health centers are a good idea to fill in the gaps. They help serve people in areas where they would have trouble getting other health care providers.

But the amount of money that is being talked about, at $125 million, to expand community health centers is barely a drop in the bucket. Remember, we are talking about 45 million or 44 million uninsured. That is about $3 a person, so you are not going to stretch it very far, unfortunately.

Mr. PUTNAM. Dr. Saving.

Dr. SAVING. I think this is a good idea, because for people who are uninsured, it is not as if they do not have access to care. Unfortunately, many of them, of course, use the emergency room as their ordinary physician.

To the extent that you can coordinate this, and move these people out of the emergency room and move them into ordinary clinics, you can perhaps save money, under the current institution.

Now another institution, which would have fewer of these people uninsured, and I would say the right kind of risk pricing for the insurance, could make these people not uninsured.

That would solve a lot of this problem. Then they would not take the emergency room, because the emergency room would be hugely expensive. The reason they take it now is, it is cheap. We have to change the relative prices.

Dr. MOON. Could I add something? I am very concerned about pricing insurance so that we divide it up with the healthy paying a low price, and the unhealthy paying a very high price.

The whole idea of insurance is the pooling of some risks. You need to balance this goal, because you do not want to price insurance so high that very healthy young people do not see any reason to buy insurance.

But I am very concerned that what could happen if we moved in that direction, would be to reduce uninsurance for those who are not going to use much health care, and raise uninsurance for sick people who need health care.

All you have to do is look at the private market now, that allows "cream skimming" where insurers decide who they take or not. It is not a pretty picture.

Dr. SAVING. No, but they "cream skim" because they are pricing at the average. If you are risk adjusting, then they would not be "cream skimming." They would like the sick people, just as well as the healthy people.

The problem with what you have here is that somebody who is chronically ill, we are not talking about insurance. That is the person whose house the hurricane has already taken out. If we rebuild his house, that is welfare. That is not insurance.

So when you take people who are sicker than other people, and try to give them the same prices as the well people, what you are doing is giving them welfare. So we should just call it welfare.

Let us not trick ourselves into thinking that is insurance and that is risk sharing. That is not risk sharing, because these are already past outcomes. Risk sharing is about the future.

So you take someone who has sick level A, and you say, I am going to insure you for the future, in case you get sick level F. But what I am going to do is charge you, based on the fact that you are now sick level A, and what the probability is that you are going to become sick level F.

That is insurance. Anything else is welfare. We can do that in the Medicare area by making the support we are going to give for individuals risk based, in this system in which they would go out and then buy insurance. They are going to get support that is risk based.

Anything else is welfare, and we should not try to call it insurance. It is spreading risk.

Mr. PUTNAM. Dr. Wilensky.

Dr. WILENSKY. It is possible that if you were to move to a system, as one that Dr. Saving describes, where you would have a so-called experience rating, and it would be based on expected use, you could make payments after the fact, for people who you believe are overly burdened by the kinds of premiums that they would face.

You do not necessarily have to try to force this mixing of risks, up front. It does raise the possibility, as we think now exists, that some individuals who would be willing to buy a risk-based insurance policy that would be low, because in fact they are low users and low expected users, would say, no thanks, because of the amount they are being asked to subsidize.

So you can subsidize people who have expected high utilization and expenditures. You do not have to just say, well, that is your tough luck. You can do it after the fact, when you see the kinds of premiums that people have to pay.

So I would like to make it clear that if you are worried about whether or not this is an unfair burden, there are other ways to handle to the problem, than to just force a pooling that goes on, up front. That is probably a discussion for another committee hearing, though.

Mr. PUTNAM. Thank you. Thank you, Dr. Wilensky, Dr. Saving, Dr. Moon. We appreciate your being here.

I want to thank all the hearty members of the committee, who stuck it out to the end, and all the members of the congressional staff and the audience, who sat through this as well, and participated in "take your son to Congress and let him Chair the meeting day."

I, again, thank the witnesses. Without any further business, the hearing is adjourned.

[Other materials submitted for the record follow:]

PREPARED STATEMENT OF HON. ANDER CRENSHAW, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you, Mr. Chairman, for holding this hearing on the President's FY2002 budget request for the Department of Health and Human Services. And, thank you, Secretary Thompson, for joining us today to discuss the programs that—along with education—form the heart of the President's compassionate conservative agenda.

Mr. Secretary, you know better than almost anyone the great success that comes from a true partnership between the Federal Government and the States. This is as true for welfare reform as it is for Medicaid and education. The key is giving States flexibility to implement the kind of reforms that work best within their borders.

When I was in the Florida Legislature, I often had the opportunity to meet with my counterparts from other States and to study their proposals and programs. We were all facing similar problems—how to provide access to quality health care for low-income families; how to stop children from having children and end the cycle of dependency on welfare; and how to improve the prospects for children who awoke everyday with no hope for a bright future. But, we all had different ideas about how to solve these problems.

It wasn't that one idea was right and the other wrong, or even that one idea was better than another. But, what works in Florida doesn't necessarily work in Wisconsin. To be sure, we can learn from each other, but States need the ability to craft the programs that suit their populations best.

This is why I am so very encouraged at your stewardship of the Department of Health and Human Services, Secretary Thompson. You know that a Federal cookie cutter approach to Medicaid, welfare, and other social service programs doesn't serve the country well. I look forward to working with you on these important programs.

Prepared Statement of Hon. Gary Miller, a Representative in Congress From the State of California

Mr. Chairman, I want to thank you for holding this hearing. I look forward to listening to the testimony and responses from Secretary Thompson before this committee.

I was delighted to hear the remarks of the President in his address last week, and am pleased with his priorities outlined in the budget blueprint. I am excited to see the President is thinking outside of the box when it comes to providing for the general welfare of the American people. I would encourage the President to continue searching for ways to use state and local government, as well using as private organizations as resources to help in this task.

I would like to hear more about some of the new initiatives proposed by the President. In particular, I am interested in the "Immediate Helping Hand" prescription drug benefit proposal. I also am interested in initiatives to help strengthen families such as the "After School Certificates" and "Promoting Responsible Fatherhood" programs. I believe that strengthening the family is the only way to decrease dependency on government services.

I am also pleased to see that this President is willing to reform areas with real policy instead of chasing problems with more money. Whether its reducing bureaucratic hurdles for patients and providers, redirecting one-time spending, or targeting selected programs for reduction, I know there are places in which we can decrease the size of government, while protecting its effectiveness. I look forward to working with the President in finding areas where the Federal Government can become more efficient.

Again, I want to thank Secretary Thompson for being here today and discussing the President's budget with this committee. I yield back the remainder of my time.

Prepared Statement of Hon. Adam Putnam, a Representative in Congress From the State of Florida

Mr. Chairman, I am looking forward to working on this committee and with our President to begin the work to reform the Medicare program. Primary concerns of mine as well as my constituents are the need for prescription drug coverage for all seniors and the lack of Medicare HMOs in my district and throughout rural America.

When I was in Florida's State Legislature, I co-sponsored the Prescription Affordability Act that extends coverage to seniors up to 120 percent of the poverty level and requires pharmacies to sell prescription drugs at Medicaid rates. As we work on including prescription drugs in a reformed Medicare system, it is of utmost importance that those seniors with incomes above poverty level are also remembered in a prescription drug program. Because of the high cost of prescription drugs, many seniors are ineligible for help, yet struggling to make ends meet and afford their prescriptions.

I have studied President Bush's "An Immediate Helping Hand" plan, and agree that an interim program could greatly benefit many of the neediest seniors until Congress completes long term Medicare reform. The President's proposal of $153 bil-

lion over the next 10 years to provide prescription drugs to these needy seniors is vital. Of extreme importance, however, is to remember those seniors that cannot afford their daily living expenses and the high cost of prescription drugs. For those seniors unable to afford the high cost of prescription drugs, implementing the President's plan to provide Medicare health care plans that provide the option of purchasing prescription drug coverage is a necessity.

Rural areas across the nation do not have access to Medicare HMOs due to funding. This is true in areas in my district as well. In Florida's 12th District, I represent counties adjacent to one another with similar characteristics. One county has availability to Medicare HMOs, while the other has no access. As the reforms for Medicare begin, suburb and rural areas across the nation that cannot attract quality providers because of low reimbursement rates must be considered. A county line is not a sufficient distinction between areas to determine the ability for an area to have access to these health care options. Exploring innovative ideas such as Medical Savings Accounts or aggressively pursuing waivers to allow residents in non-served areas access to the services covered by Medicare HMOs in other counties are possible options.

As we consider the budget for Medicare reform, it is vital that we consider the impact it will have over the next 50 years, not just the next fiscal year. We need to develop a generational consensus on ensuring that Medicare will be available to the retiring seniors of today, for baby boomers and beyond. I intend to be involved in this process.

I thank the Secretary for his thorough outline of the Administrations proposal for Health Care reform and I thank to Dr. Gail Wilensky, Dr. Thomas Saving, and Dr. Marilyn Moon for their thoughts as well. I look forward to being a part of modernizing Medicare to accommodate the changing needs of seniors today, and the seniors of tomorrow.

TESTIMONY FOR THE RECORD BY THE ADVANCED MEDICAL TECHNOLOGY ASSOCIATION

AdvaMed is the largest medical technology trade association in the world, representing more than 800 medical device, diagnostic products, and health information systems manufacturers of all sizes. AdvaMed member firms provide nearly 90 percent of the $68 billion of health care technology products purchased annually in the U.S. and nearly 50 percent of the $159 billion purchased annually around the world.

AdvaMed strongly supports the President's commitment to the Medicare program and medical research. With great interest, we note that President Bush's budget blueprint states that "Medicare is not adapted to 21st Century medicine. Medicare is often too slow to incorporate technologies and methods of delivering care * * * As in virtually all fields, technological and entrepreneurial innovation are among the keys to creating more value for the dollar in health care."

We strongly agree that Medicare should be encouraged to capitalize on advanced technologies, which have revolutionized the U.S. economy and driven productivity to new heights and new possibilities in many other sectors. Significant advances in health care technologies—from health information systems that monitor patient treatment data to innovative diagnostics tests that detect diseases early and lifesaving implantable devices—improve the productivity level of the health care delivery system itself and vastly improve the quality of the health care delivered. New technologies can reduce medical errors, make the system more efficient and effective by catching diseases earlier—when they are easier and less expensive to treat, allowing procedures to be done in less expensive settings, and reducing hospital lengths of stays and rehabilitation times.

AdvaMed applauds Congress for the steps it took in the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act (BIPA) of 2000 to begin to make the Medicare coverage, coding and payment systems more effective and efficient. In addition, the Health Care Financing Administration (HCFA) has recently made some changes to modernize its coverage and payment systems.

Despite these efforts, however, current policies still fail to keep up with the pace of new medical technology. Serious delays continue to plague the amount of time it takes Medicare to make new medical technologies and procedures available to beneficiaries in all treatment settings.

As Cliff Goodman from the Lewin Group testified at a March 1st hearing in the committee on Energy and Commerce, Medicare delays can total from 15 months to 5 years or more because of the program's complex, bureaucratic procedures for adopting new technologies. Keep in mind that all this is after the two to 6 years it takes to develop a product and the year or more it takes to go through the Food and Drug Administration (FDA) review. In addition, these delays are even more pro-

nounced when you consider that the average life span of a new technology can be 18 months.

The impact on patients has been dramatic. As physician witnesses testified on March 1st, cancer patients have had to fight for years to get Medicare to cover positron emission tomography, a potentially lifesaving scanning technology that has been broadly available to people under private health insurance for a decade. In addition, tens of thousands of seniors and people with disabilities have not been able to receive advanced technologies like coronary stents (which reopen blocked arteries), cochlear implants (which restore hearing) and heart assist devices (which keep patients alive while waiting for a heart transplant).

These delays stem from the fact that for a new technology to become fully available to Medicare patients, it must go through three separate review processes to obtain coverage, receive a billing code and have a payment level set. Serious delays in all three of these areas create significant barriers to patient access.

While HCFA has improved the transparency for making national coverage decisions and attempted to instill timeframes within the process, timeliness is still a major problem. Under the current national coverage process framework, HCFA has 90 days to determine whether it will make a coverage decision or refer the request to either the Medicare Coverage Advisory Committee (MCAC) or an outside health technology assessment (HTA) group—or sometimes even to both. These outside assessments take between 3 and 12 months each. HCFA then has 60 days to review the recommendations of the MCAC or HTA, and should a positive coverage determination be made, it takes 180 days from the first day of the next calendar quarter to issue a code and set a payment level.

The coverage process should be streamlined and made more accountable, timely and transparent. Steps should be taken to reduce redundancies in the MCAC panel and HTA reviews. In addition, the focus of the MCAC panels should be directed toward gaining practical clinical advice from the medical experts on its panels.

After coverage is approved, there are three separate coding processes that determine how a device or procedure is identified and to which payment bundle it is assigned. Each of these coding systems have significant time-lags in assigning and updating codes. Under the new hospital outpatient perspective payment system (PPS), HCFA now assigns and updates codes on a quarterly basis. To reduce coding delays of 15–27 months, HCFA should use the outpatient PPS system as a model for applying similar systems to other settings, such as the inpatient hospital setting and doctors' offices.

Coverage and codes mean very little, however, if the associated payment level is inadequate. HCFA's procedures for updating relative payment weights and reassigning technologies and procedures are informal and infrequent. For example, it took HCFA 5 years to ultimately decide that the applicable diagnosis related group (DRG) should be split into two DRGs for angioplasty with and without stent. During those 5 years, hospitals took significant losses on each stent procedure and the diffusion of this cost-saving technology was hampered.

As required by BIPA, HCFA should develop formalized procedures for expeditiously assigning codes, updating relative weights and reassigning technologies to recognize the value of new and substantially improved technologies. HCFA should also fully implement the BIPA requirement to provide a transitional payment mechanism for new technologies where the DRG payment is inadequate.

Again, AdvaMed applauds Congress and the President for recognizing the value of technology in improving the quality and efficiency of the health care system. We look forward to working with Congress, the President and Secretary Thompson on ways to modernize Medicare, incorporating the benefits technology can bear, and furthering advances in medical research.

[Whereupon, at 4:25 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

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