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LRM ID: RJP12

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

URGENT

Monday, February 10, 1997

LEGISLATIVE REFERRAL MEMORANDUM

TO:	Legislative Liaison Officer - See Distribution below
FROM:	Janet R. Forsgren (for) Assistant Director for Legislative Reference
OMB CONTACT:	Robert J. Pellicci
	PHONE: (202)395-4871 **FAX:** (202)395-6148
SUBJECT:	HHS Oversight Testimony on President's FY 1998 Proposals for Medicare and Medicaid
DEADLINE:	**10:00 a.m. Tuesday, February 11, 1997**

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: The attached testimony will be used: (1) before the House Commerce Subcommittee on Health on Wednesday, February 12th, and (2) before the House Committee on Ways and Means on Thursday, February 13th. Bruce Vladeck is the Administration witness.

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RESPONSE TO
LEGISLATIVE REFERRAL
MEMORANDUM

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

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The following is the reponse of our agency to your request for views on the above-captioned subject:

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MEDICAID PORTION

Statement of Bruce C. Vladeck
Administrator, Health Care Financing Administration

Before the House Commerce Committee Subcommittee on Health
February 12, 1997

Overview: President's FY1998 Budget Proposal

The President's Budget Proposal for 1998 reflects the continuing commitment of this Administration to assure high quality health care for Medicare and Medicaid beneficiaries while working toward providing health care coverage for all Americans. The President's Medicaid proposal guarantees coverage for Medicaid beneficiaries; addresses the needs of States for greater flexibility; and responsibly controls expenditures while investing wisely in expanded coverage, especially for children.

While reforming and streamlining Medicaid, the President's plan saves a net $9 billion over the next 5 years. This is achieved by limiting Federal spending on a per person basis and by reducing and retargeting Disproportionate Share Hospital (DSH) payments to facilities that serve large numbers of Medicaid and uninsured patients. The President's Budget also includes several Medicaid initiatives that address the health care needs of children and individuals adversely affected by the new Temporary Assistance for Needy Families legislation. In addition, our new Children's Initiative would provide health insurance to as many as 5 million children who would otherwise be uninsured or who are not now enrolled in Medicaid.

In addition, the President's plan provides States with much greater flexibility to develop innovative and more efficient health care delivery and payment systems. These proposals would provide new opportunities for States to generate administrative and program savings and expand health care coverage.

The Medicare provisions in the President's Budget are part of an aggressive strategy to strengthen Medicare and modernize it for the 21st century. Our goal is to become a more prudent purchaser of high quality health care that meets the needs of all of our beneficiaries, especially the most vulnerable. Almost 75 percent of Medicare beneficiaries have incomes below $25,000, and while the average American household spends 4 percent of its income on health care, elderly Americans spend nearly 21 percent of their income on health care services. The President's proposal strengthens Medicare through structural reforms, operational modernization, greater market responsiveness, and improved benefits.

THE MEDICAID PROGRAM

1998 Budget Savings

During FY 1996, Federal Medicaid expenditures were $92 billion and helped pay for services to nearly 37 million Medicaid beneficiaries. In the President's 1998 Budget Proposal we achieve gross savings of $22 billion over 5 years. About $9 billion in savings over the next 5 years will be used to reduce the budget deficit. Because recent Medicaid expenditures as well as those projected over the next 5 years have grown more slowly than expected, the $9 billion net savings proposed in this budget is considerably lower than what was proposed during the last Congress.

Last year, there was actually a decline in Medicaid spending growth. The first chart shows this decline. The 1996 growth in overall Medicaid expenditures was less than 4 percent. The Administration now projects that Medicaid spending over the next 5 years will be at least $68 billion less than projected a year ago in the President's 1997 budget.

The main reason for this notable decline in the Medicaid growth rate is legislative changes enacted in 1991 and 1993 limiting spending on Disproportionate Share Hospitals (DSH) and putting restrictions on Federal matching on provider donations and taxes. These bipartisan solutions to the problem of overuse of both DSH and provider donations and taxes in the late 1980s slowed the total expenditures growth from its all-time high of 31.7 percent in FY1991 to a 6.4 percent level projected between 1998 and 2002. States have also contributed to lower growth rates by using their new flexibility to contain costs.

Despite the reductions in the baseline, Medicaid savings are still needed. Our experience over the last 5 years shows how hard it is to make long term Medicaid spending projections. We firmly believe that, as part of a balanced budget strategy, we must have a way to protect against future growth in Medicaid expenditures.

In fact, we expect Medicaid growth rates to begin to increase again, beginning in 1998. Under the Administration's new baseline projections, the aggregate Medicaid growth rate would be about 7.5 percent over the next 5 years. This is due to increases in the number of beneficiaries served and medical price inflation, as well as a maturing of the managed care industry. CBO estimates that between 1998 and 2002 the average growth rate in total Medicaid spending will be approximately 8.1 percent.

Investments

Child Health

There are 10 million uninsured children in America today, a problem this Administration intends to address. Uninsured children tend to fall into three categories: 1) those who are eligible

for Medicaid but not enrolled; 2) so-called "gap" children whose family income is too high for Medicaid eligibility but not enough to afford private insurance; and 3) those whose employer-sponsored coverage is intermittent due to fluctuations in their parents' work status. The goal of the President's child health proposals is to begin to address the insurance and access needs of at least half of America's uninsured children in the next 4 years. We have developed a multi-dimensional approach to addressing this complex problem. The next chart shows the number of children we expect to cover using both Medicaid and private sector insurance initiatives. We will finance the Medicaid expansions in these initiatives through Medicaid savings and the non-Medicaid investments through savings achieved elsewhere in the President's Budget.

We propose two Medicaid initiatives. First, we would guarantee at least 12 months of continuous eligibility for children ages one and older once they have become eligible for Medicaid. Many children currently have less than a year of Medicaid coverage each year. This proposal is especially beneficial to children with family incomes near the Medicaid eligibility income limit. If States choose this program, over one million children, who otherwise would have been covered intermittently, would have continuous coverage for a full year. Second, we would reach out to an estimated three million poor children who are currently eligible for Medicaid, but are not enrolled. We would work actively with the states to identify and enroll them.

We also propose two approaches to expand private insurance coverage for children. First, we will fund $750 million per year in partnership grants to States to support programs to cover children who are not now covered by Medicaid or health insurance or who have inadequate coverage. This new program is expected to reach 1 million currently uninsured children through a variety of approaches that States have broad flexibility to design. An important component of this proposal is the spillover effect on Medicaid enrollment -- we estimate outreach conducted as part of this program will find as many as 400,000 children, who are eligible for Medicaid. Second, the President's Healthy Working Families initiative would provide up to 6 months of premium assistance to workers who are between jobs, an initiative expected to cover 3.3 million Americans in 1998, including 700,000 children.

In addition, under a previously enacted phased- in expansion of coverage for children between the ages of 14 and 18, we expect States will enroll an additional 250,000 low-income children in each of the next 4 years.

Welfare Reform Adjustments

The recently enacted welfare legislation particularly affected children and immigrants. Because of the historically close links between eligibility for cash assistance and eligibility for medical assistance, a wide range of Medicaid issues need to be addressed as a result of the new legislation.

The welfare legislation severed the link between the receipt of cash benefits under AFDC

and automatic eligibility for Medicaid, but maintained the current Medicaid rules. States are required to use the rules in place on July 16, 1996 to determine the Medicaid eligibility of AFDC-related groups. However, several issues remain with respect to Medicaid, including assuring that: eligible individuals continue to be enrolled; eligible disabled children do not lose Medicaid due to the changed SSI childhood disability definition; and medical assistance continues to be available for eligible legal immigrants.

The President's 1998 Budget Proposal would invest in significant adjustments to the new welfare rules to guarantee medical care for certain immigrants who lose health coverage as a result of welfare reform. States would again be able to provide Medicaid coverage for legal immigrants who qualify as SSI recipients who become disabled after entry into the United States. Disabled immigrants and children would not be subject to the 5-year Medicaid ban nor would their sponsor's income and assets have to be considered in determining their eligibility for Medicaid. Refugees and asylees, facing persecution in their own country, would receive additional protection from the sponsor deeming rules.

We would invest additional dollars to retain Medicaid coverage for disabled children who lose SSI cash benefits as a result of the new childhood disability definition in the welfare reform legislation.

Last year's welfare reform legislation provided for $500 million to help with the additional administrative burden imposed on States by the need to maintain and operate two separate eligibility processes. The law charged the Secretary with developing a plan for equitable distribution of this money, and we have worked with intergovernmental groups representing the Governors, Legislatures, and State welfare and Medicaid agencies in determining the method and factors to be used in allocating this money. We will soon publish a Federal Register notice proposing that each State receive a minimum base amount of $2 million and that the rest of the funding be distributed based on State Medicaid administrative expenditures, State AFDC caseload, SSI children in the State, and SSI immigrants in the State.

Per Capita Cap

The per capita cap establishes new accountability in spending growth per Medicaid beneficiary while guaranteeing Federal matching funds for eligible individuals for a guaranteed set of benefits and protecting States and beneficiaries during periods of economic recession and other changes that may increase Medicaid rolls.

We believe that the per capita cap as described below is the best way to achieve budgetary discipline in the Medicaid program. The per capita cap is designed to maximize States' responsiveness to the health care needs of their Medicaid populations while adapting to changing economic circumstances.

Certain aspects of Medicaid spending not tied to individual beneficiaries or not under

direct control of the States would not be subject to the cap: vaccines for children, payments to Indian health providers and the Indian Health Service, Disproportionate Share Hospital (DSH) payments, and Medicare premiums and cost sharing for dual eligibles and qualified Medicare beneficiaries (QMBs). On the other hand, Medicaid expenditures for services delivered under Section 1115 demonstration waivers would be subject to the per capita cap.

The per capita cap is calculated based on an estimate of what spending would be if spending growth per beneficiary were limited to a specified index. The cap applicable to a given State in a given year would be an aggregate of the individual caps for four groups of beneficiaries in the State: aged, disabled, adults in families with children, and children. The cap for each group would be the product of:

- total State and federal spending in the previous year, including administrative costs, per beneficiary in the group;
- the number of beneficiaries in the group for the current year;
- an inflation index; and
- the federal matching rate.

The spending for each of the four groups would be combined to establish the spending limit for the State. Medicaid spending would grow in future years by an index factor. Each State would be able to use savings from one group to support expenditures for other groups or to expand benefits or coverage. The Federal match would continue until the total capped amount for the State is reached.

It is clear that we would need the best possible data to implement a per capita cap appropriately for each State. We would need to make some modifications to the existing data reporting systems. For example, we would need all States to participate in the Medicaid Statistical Information System (MSIS) program in which twenty-nine States now participate. MSIS permits collection and analysis of person-based data on eligibles, recipients, utilization and payment for Medicaid services. This data is already extremely useful for State program management and federal analysis and monitoring under current law and would be vital to successful implementation of the per capita cap.

Disproportionate Share Hospitals

As the final chart shows, Medicaid spending for disproportionate share hospitals increased from well below $1 billion in 1988 to $10 billion by 1992. Laws enacted in 1991 and 1993 have slowed this growth; however, today's Disproportionate Share Hospitals (DSH) program is still too large.

A recent study by the Urban Institute of the Medicaid Disproportionate Share and Other Special Financing Programs in 39 States demonstrates that a significant number of Medicaid DSH dollars are being spent at the State level without demonstrable benefit to Medicaid recipients or reduction in uncompensated care. The Urban Institute found that even after the implementation of

the Disproportionate Share Hospitals program changes enacted in 1991 and 1993, "approximately one-third of total DSH expenditures leave the health care system." The Urban Institute study asserted that these funds that "leave the health system" are used by States for other, non-health related purposes.

We propose to achieve two-thirds of our total Medicaid savings through reductions in the Disproportionate Share Hospitals program. At the same time, we would retarget the funds to providers that have a disproportionate share of low income patients. There would be reductions in DSH spending for all States, including those States with DSH programs operating under Section 1115 demonstration waivers.

The retargeting plan would protect institutions providing uncompensated care, such as children's hospitals and public hospitals. In consideration of the growing importance of ambulatory settings, we would allow States to target a portion of DSH funds to providers such as ambulatory care centers, Rural Health Centers and Federally Qualified Health Centers.

State Flexibility

Under current law, States have considerable flexibility in managing their Medicaid programs. A reflection of this flexibility is the fact that only 45 percent of program funding goes toward mandatory services for mandatory eligibles. The other 55 percent is spent by the States for services to individuals that they have chosen to include in their programs. We plan to further enhance State flexibility while protecting beneficiaries and maintaining fiscal accountability.

The President's Budget eliminates some current law restrictions on States' ability to set provider payments. The Budget would repeal the long-criticized Boren Amendment, which limits the way States can set their provider reimbursement rates for hospitals and nursing homes. States would be able to use a simplified public notice process for setting hospital and nursing home payment rates. The Budget would also phase out in 1999l the requirement for cost-based reimbursement for FQHCs and Rural Health Clinics; however, we will create additional flexibility for States to use DSH funding for Federally Qualified Health Centers.

The President also proposes increased flexibility for Medicaid managed care programs. Various provisions would eliminate the need for a waiver for mandatory managed care; replace the 75/25 enrollment composition rule with enhanced quality monitoring systems; permit nominal copayments for HMO enrollees; and require an actuarial review of the upper payment limit and the soundness of capitation rates so that they will reflect historical managed care costs.

Another provision would increase States' flexibility to cover people with incomes up to 150 percent of the Federal poverty level. This proposal lets States cover new groups and employ simplified eligibility rules without applying for a Federal waiver.

The President's Budget Proposal would also eliminate a number of unnecessary

DJDade

hcfa waiver

administrative requirements. We would replace the physician qualification requirements for obstetrical and pediatric services with State certification of those providers. We would eliminate what we have found to be unnecessary annual State reporting requirements regarding beneficiary access to obstetricians and pediatricians as well as the requirement that States pay for private health insurance premiums for Medicaid beneficiaries where cost-effective. States would be able to use general performance parameters for electronic claims processing and information retrieval systems instead of detailed Federal standards for computer systems design.

The budget balances these changes with a significantly improved quality assurance process focusing on internal and external quality assurance mechanisms, clear and understandable grievance processes, and ample public notice requirements.

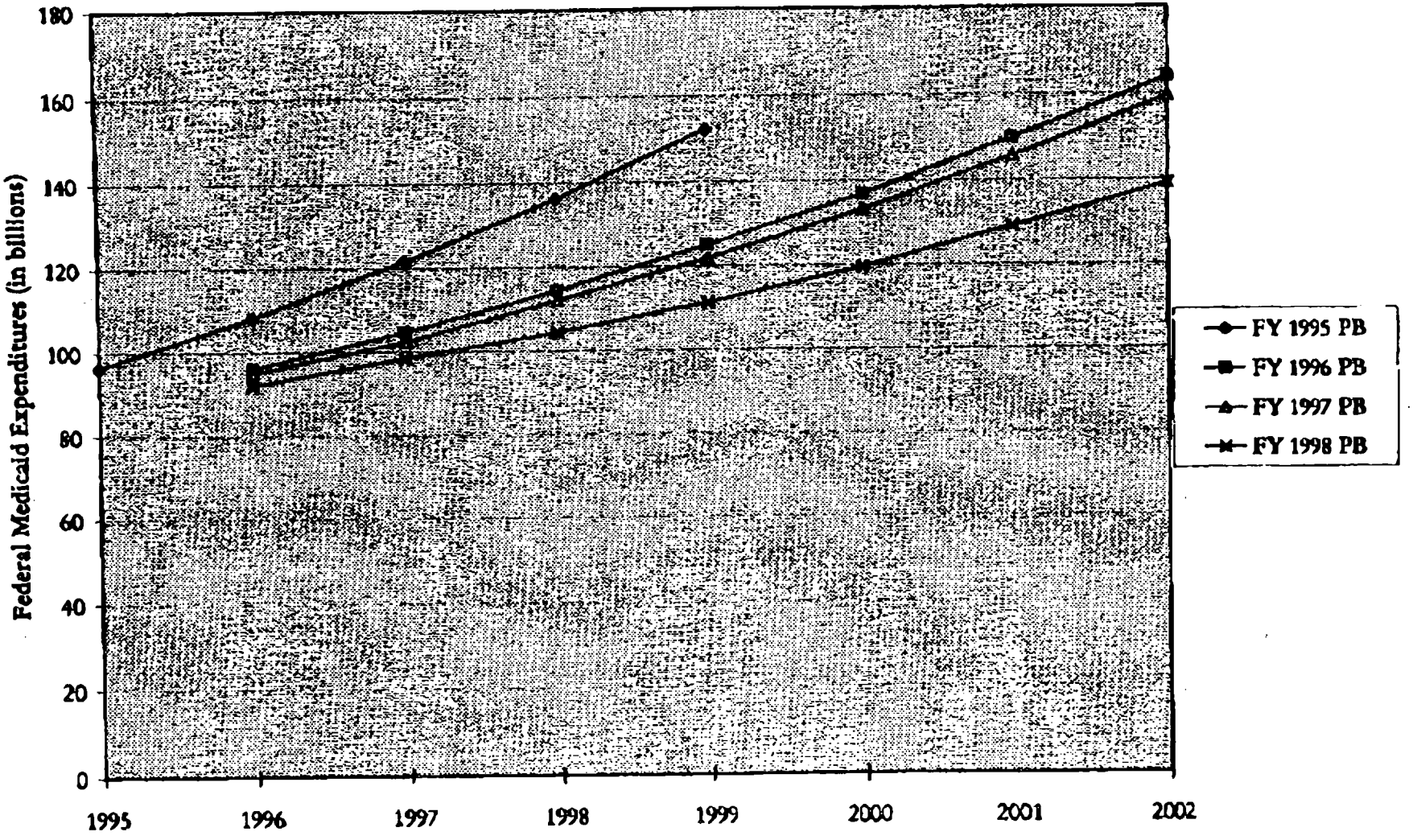
THE MEDICARE PROGRAM

[Appropriate sections of the cleared version of the Administrator's February 13 testimony before the Ways & Means Committee to be added here.]

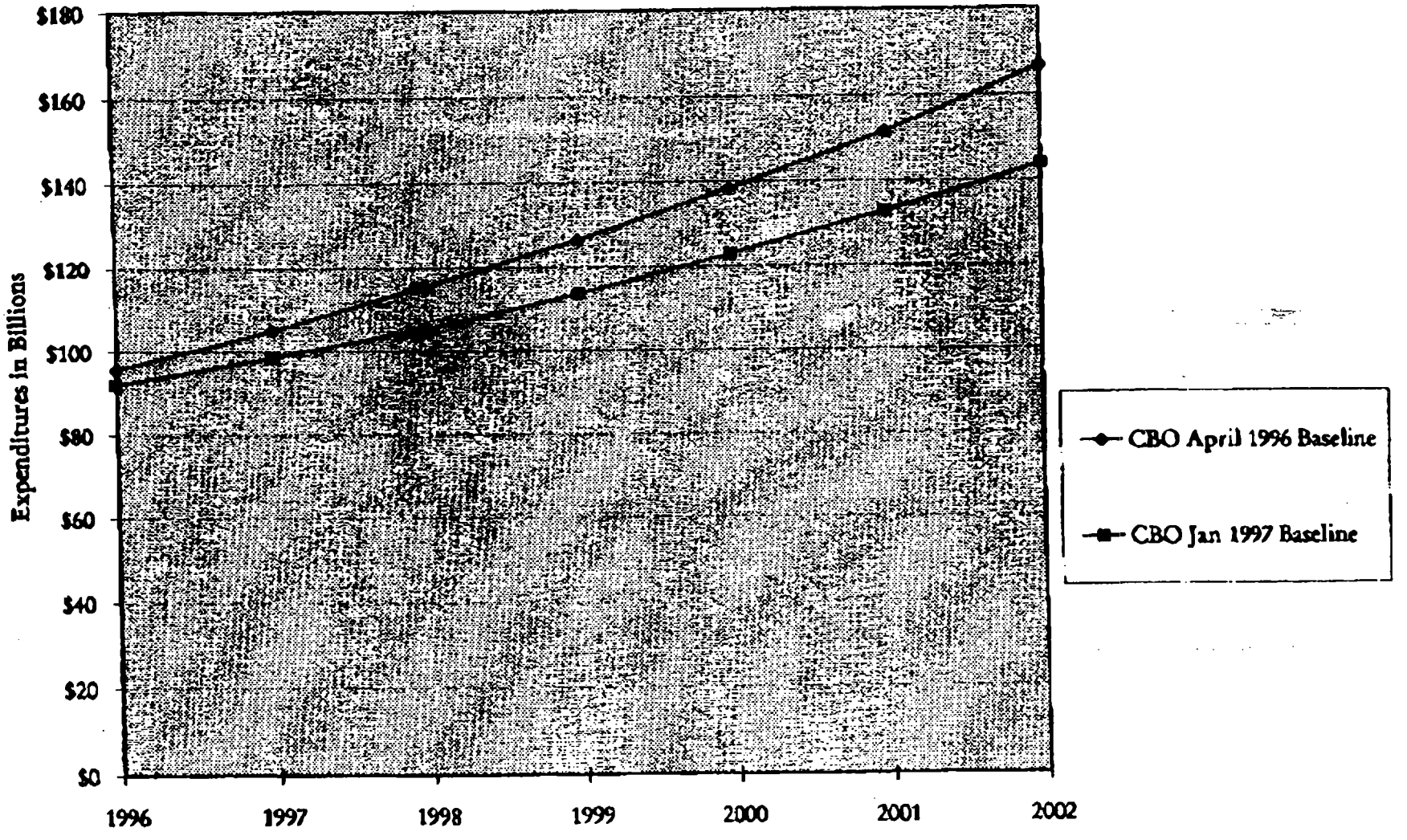
CONCLUSION

We believe that the Administration's proposals outlined above are the best way to work toward our shared goals of providing access to quality health care for all Americans. For Medicaid, the President's 1998 Budget would continue the safety net protection for our most vulnerable citizens, achieving savings through greater flexibility for States to run more efficient Medicaid programs. The Medicare proposals would guarantee that the program continues to pay for health care services for Americans who need them, that it is structured to provide the best health care now and in the future, and that the nation continues to be able to afford it. I will be pleased to answer any questions you may have on the President's proposals.

Decline of the President's Medicaid Baseline



Decline of the 1996-2002 CBO Medicaid Baseline



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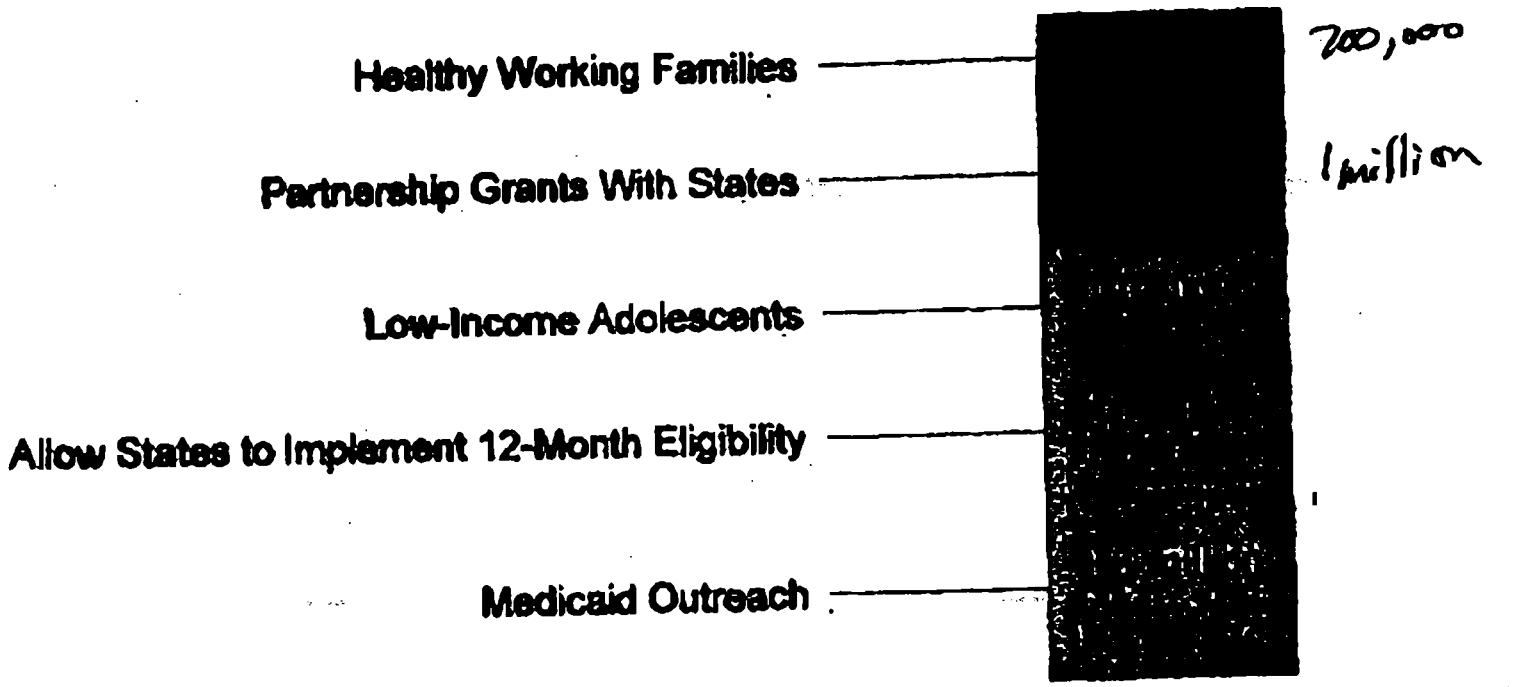
Children's Health Initiative

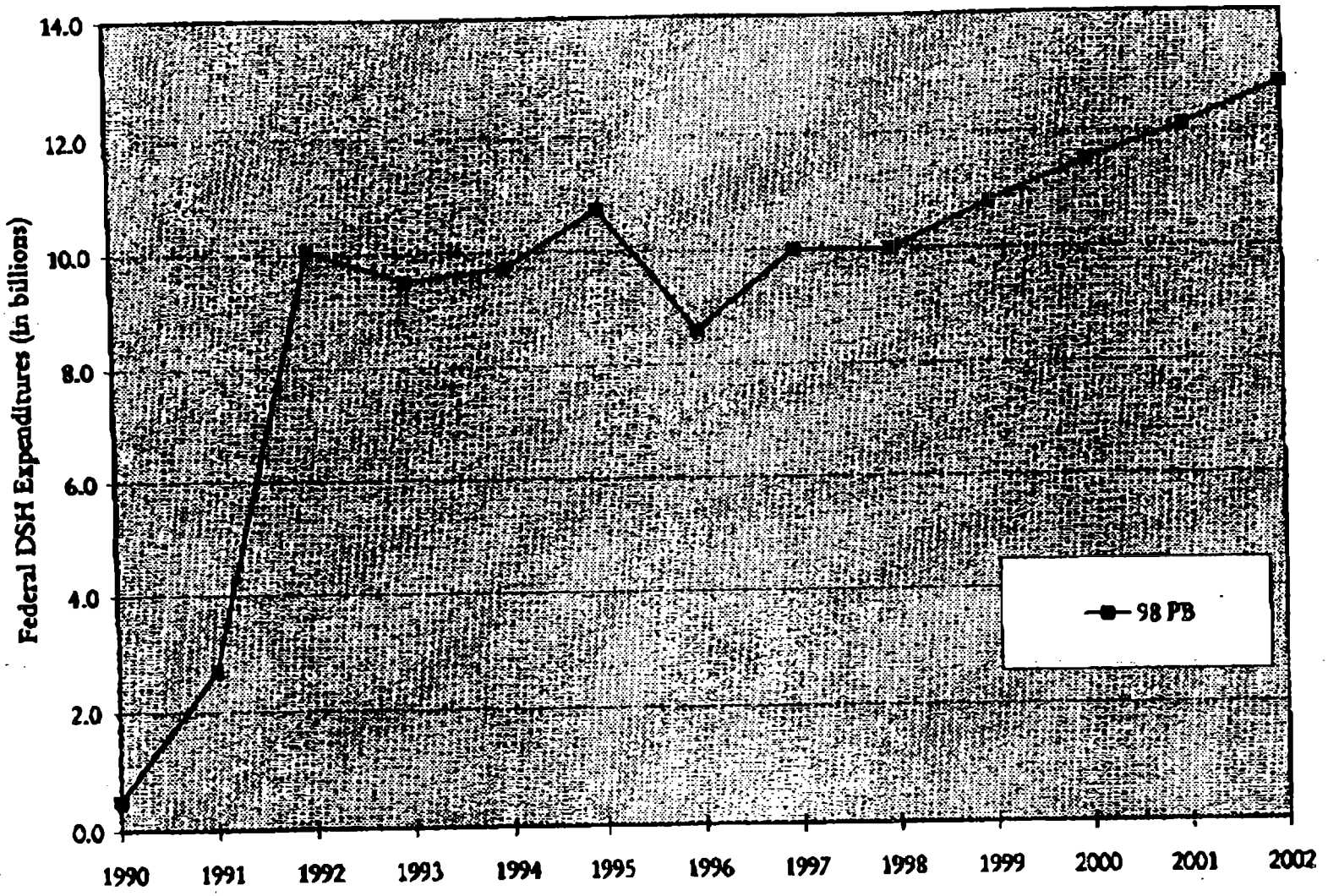
Potential Number of Children Covered by 2000



Department of Health and Human Services estimates.
Illustrative estimates of potential coverage assume all states and partners participate in programs.
Estimates do not account for overlap between target populations.

DSH Spending Over Time

Source: 98 President's Budget and Historicals



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MEDICARE PORTION

Statement of Bruce C. Vladeck
Administrator, Health Care Financing Administration

House Ways and Means Committee; Subcommittee on Health
February 13, 1997

INTRODUCTION

Mr. Chairman, I am pleased to have the opportunity to present the Administration's plan for modernizing Medicare. I am enthusiastic about the initiatives we have undertaken to ensure that Medicare is strengthened for the 38 million Americans who depend upon it, offers the best possible medical care, and enters the next century in robust condition.

The President's Budget reflects a broad strategy for reforming Medicare. It does not, however, "restructure" Medicare if restructuring is defined as shifting a higher proportion of the costs of the program to beneficiaries. Nor do we propose to "restructure" the program by limiting the government contribution to some arbitrary amount, shifting all financial risk to beneficiaries. We think it is important to put a human face on the equation and to be fully aware of the serious impact such proposals would have on Americans least able to bear these additional cost burdens. Although only 10-12% of Medicare beneficiaries fall below the Federal poverty line, nearly 75% have incomes below $25,000. **[CHART #1 - INCOMES OF ELDERLY]** An elderly retiree trying to make ends meet on $14,000 a year cannot afford to pay additional health care costs, when that person may be faced with a choice between medicine or a meal. **[CHART #2 - PROPORTION OF INCOME SPENT ON HEALTH]** Recent data indicates that the elderly already spend a formidable 21% of their income on health care, compared to 8% spent by the non-elderly. It is clear from this data that shifting costs to Medicare beneficiaries will have serious consequences.

Our goal at the Health Care Financing Administration is twofold: with the President's legislative proposals, we will modernize Medicare and extend the Trust Fund solvency for the next decade, which will contribute to reduction of the deficit. Through sound judgment and careful planning, we can guarantee that the Medicare program of the future will continue to provide the same protections to the elderly and disabled as it does today.

MODERNIZING MEDICARE

The President's Budget modernizes Medicare and brings it into the twenty-first century through major structural changes in seven areas: Preventive Care; Beneficiary Protections; Program Improvements; Modernizing Managed Care Choices; Prudent Purchasing; Integrated Quality Management; and Improving Access in Rural Areas.

1 - PREVENTIVE CARE

One of the core elements of our restructuring agenda is modernization of the Medicare program's preventive care. The cost-effectiveness of illness prevention is well-known; in the long run, preventive medicine pays for itself. The President's Budget would make some significant improvements in the area of preventive benefits. I would note that there is a bipartisan consensus on many of these proposals as indicated by the similarities between our initiatives and legislation written and sponsored by Chairman Thomas, Mr. Cardin and Mr. Billirakis. We look forward to working with you to enact these new benefits:

Colorectal Screening Coverage - Colorectal cancer is the second most common form of cancer in the U.S. and has the second highest mortality rate. Yet, despite the demonstrated importance of early detection, Medicare does not pay for procedures used to detect colorectal cancer when used as a screening tool. The President's budget would provide such coverage, thereby increasing the possibility of early detection and treatment of colorectal cancer.

Mammography Coverage - The early detection and treatment of breast cancer is a high priority for HCFA. 48 percent of new breast cancer cases and 56 percent of breast cancer deaths occur in women age 65 and over. Although Medicare covers both screening and diagnostic mammography, only 40 percent of all eligible beneficiaries over age 64 (excluding those in managed care) received a mammogram in the two-year period from 1994 through 1995. In addition, only 14 percent of eligible beneficiaries without supplemental insurance received mammograms during the first two years of the screening mammography benefit, which began in 1991.

The President's budget expands coverage for screening mammograms to provide for an annual mammogram for women age 65 and over. This is consistent with the frequency recommendations of most major breast cancer authorities. The budget also proposes to waive cost-sharing for mammogram services in order to encourage their use.

Expanded Benefits for Diabetes Outpatient Self-management Training and Blood Glucose Monitoring - The third area where we propose to make investments is in services for beneficiaries with diabetes. Under current law, Medicare covers diabetes outpatient self-management training only

in hospital-based programs, and covers blood glucose monitoring (including testing strips) only for insulin-dependent diabetics. The President's budget would expand coverage of diabetes outpatient self-management training to non-hospital-based programs, and expand coverage of blood glucose monitoring (including testing strips) to all diabetics.

Preventive Immunizations - Current law provides payment for the administration of pneumonia, influenza, and hepatitis B vaccines, and already waives payment of coinsurance and the Part B deductible for pneumonia, influenza, and hepatitis B vaccines. The President's budget increases payment amounts for the administration of all three types of vaccines, and waive payment of coinsurance and applicability of the Part B deductible for hepatitis B vaccine. These measures will improve access to adult vaccinations and make the cost-sharing waiver consistent for all types of covered vaccines.

2 - Beneficiary Protections: Coinsurance Reform and Enrollment Improvements

Reform Beneficiary Coinsurance for Hospital Outpatient Department Services - Coinsurance for Part B services is generally based on Medicare's payment amount. However, for certain outpatient department services (OPDs), coinsurance is a function of hospital charges, which are significantly higher. In addition, as a result of a flaw ("formula-driven overpayment") in the statutory formula determining Medicare's payment for certain OPD services, hospitals have had an incentive to increase their charges. The net effect of charged-based coinsurance and hospitals' increases in their charges is that in 1998, without a change in law, beneficiaries will pay an effective coinsurance rate of 46 percent rather than 20 percent for most OPD services. This effective coinsurance rate is expected to increase to 52 percent by 2007.

The President's budget proposes establishing a prospective payment system (PPS) for OPD services in 1999. Total payments to hospitals for OPD services will be established so as to equal total payments that would otherwise apply, minus the effect of the formula driven overpayment. This also assumes the extension of certain OPD policies included in OBRA 93 that are slated to expire in 1999. Coinsurance will be reduced in 1999 using the savings from the formula-driven overpayment. It would also be gradually reduced in subsequent years until it would be equal to 20 percent in 2007.

Part B Enrollment and Premium Surcharge - Under current law, with certain exceptions, beneficiaries who do not enroll in Part B when they are first eligible can enroll subsequently only during an annual open enrollment period from January to March of each year, with coverage effective in July. In addition, for each year that they could have enrolled in Part B but did not, they face a 10 percent premium surcharge. While for most beneficiaries the surcharge is in the 20-30 percent range, some beneficiaries face a surcharge of 150 percent or more -- an amount which is punitive rather than bearing any relationship to the cost to Medicare of late enrollment.

In recent years, flaws in this enrollment process and inequities in the premium surcharge have become obvious. Beneficiaries who never enrolled in Part B due to availability of other coverage have attempted to enroll after their circumstances changed. For example, beneficiaries may have not have enrolled In Part B because they had generous retiree coverage through their former employers. Years later, however, they were informed that the former employer was now requiring Part B enrollment or was dropping coverage entirely. There are also situations where military retirees did not enroll in Part B because they could obtain physicians' services through a clinic at the military base near their home. Then, years later, the closing of their base necessitated Part B coverage.

The President's budget replaces the annual general enrollment period for Part B with a continuous open enrollment period. Beneficiaries will be able to enroll in the program at any time, with coverage beginning six months after enrollment. Also, the Part B premium surcharge for late enrollment will be revised based on the actuarially determined cost to Medicare of late enrollment. This provision will provide substantial relief to thousands of beneficiaries.

3 - PROGRAM IMPROVEMENTS

Respite Benefit - The President's Budget creates a respite benefit, beginning in FY 1998. This much-needed benefit will provide up to 32 hours of care each year for beneficiaries suffering from Alzheimer's and other irreversible dementia. Respite care may be provided at home or at a day-care facility, and will serve to ease the emotional "burnout" that is commonly experienced by primary caretakers, especially when they are family members. As the longevity of the population increases, greater numbers of Americans will be faced with the challenge of caring for aged and infirm family members at home. In the spirit of the Administration's efforts to improve the quality of family life, this benefit is an important step toward a community- and family-centered approach to health care.

Social Security Disability Demonstration - Lack of health coverage is often a barrier to the disabled in their efforts to go back to work, since after a transition period they are ineligible to receive premium-free Medicare Part A coverage. The Social Security Disability Demonstration (SSDI) will allow certain SSDI beneficiaries to receive premium-free Part A coverage for up to four additional years.

Reallocation of Some Home Health to Part B - Home health care plays a significant role in the Medicare infrastructure, especially since 33% of home health users live alone, and 43% have incomes below $10,000. **[CHART # 3 - CHARACTERISTICS OF HOME HEALTH USERS]** Under the Administration's proposal, the first 100 visits following a three-day hospital stay would be reimbursed under Part A, just as this program covers 100 days of skilled nursing care following a hospitalization. All other home health care (visits beyond 100 and those not following a hospital stay) would be paid under Part B. Prior to OBRA 80, the Part A portion of the home health benefit was

limited in this way. OBRA 80 legislation eliminated the three-day hospitalization requirement and the visit limits, and in so doing burdened Part A with almost all of the financing of home health. The restoration of non-post acute visits to Part B makes the home health benefit consistent with the original intent of the Medicare statute and its division of services between Part A and Part B.

4 - Modernizing Managed Care Choices

Under our Medicare Choices initiative, we would expand managed care options, provide beneficiaries with comparative information on all of their health care choices, ease comparison among options by increasing standardization of benefits, provide a coordinated open enrollment period and other open enrollment opportunities and institute Medigap reforms. Let me address each of these components separately.

Expanded Managed Care Options - Currently, HCFA can contract with Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to serve as Medicare managed care plans. The Administration believes that Medicare beneficiaries should have more managed care choices, comparable to those available in the private sector. Thus, the President's budget would expand managed care options to include Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs). We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care to rural areas.

Comparative Information - Under current law, beneficiaries may obtain comparative information on Medigap options through State Insurance Counseling Grant Programs. Some of these programs also address managed care options. There are no mechanisms, however, to ensure that beneficiaries are aware of all their options, in both managed care and Medigap. Under the President's budget, the Secretary will develop and provide comparative information to beneficiaries on all managed care plans and Medigap plans in the area. This information will be used by State Insurance Counseling Grant Programs to assist beneficiaries in understanding their coverage options. The costs of preparing and disseminating this information and supporting the State Counseling Grant Program will be financed by the Medigap and managed care plans.

Standardized Benefits - While comparative information will be helpful to beneficiaries, making an informed decision among the array of available coverage options would be hampered unless differences in benefit packages are addressed. Under the President's budget, the Secretary will establish standardized packages for certain additional benefits offered by managed care plans. For example, if the Secretary established a standardized package for outpatient prescription drugs, plans could offer enrollees this benefit only according to the structure established by the Secretary. The development of standardized additional benefit packages will make it possible for beneficiaries to compare these benefits on the basis of cost and quality. The National Association of Insurance

Commissioners (NAIC) will also review the current standard Medigap packages to see if changes could be made to ease comparison with the standard managed care benefits.

Open Enrollment Opportunities - Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare by virtue of a disability or end-stage renal disease beneficiaries have no such choice. If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual's poor health status. As a result, beneficiaries reluctant to try managed care or fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap.

The President's Budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans will have to be open for a one month coordinated open enrollment period. Additional open enrollment opportunities will be available under certain circumstances -- such as, when a beneficiary's primary care physician leaves a plan or when a beneficiary moves into a new area. While the concept of coordinated open enrollment is not new and was included in the Budget Bill in 1995, the key difference in our proposal is the inclusion of Medigap plans.

Other Medigap Reforms - In addition to addressing open enrollment, there are other Medigap reforms included in the President's budget. We would like to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President's budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bill introduced by Rep. Johnson during the last session and we look forward to working together toward enactment this year.

Our final Medigap reform addresses rating. There are currently no federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice beneficiaries to enroll in their fledgling stages, but as the company matures it raises the premiums to unaffordable levels. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Also, if we are serious about choice, we should not allow premium structures, such as attained age rating, which in effect make Medigap unaffordable as beneficiaries age.

5 - PRUDENT PURCHASING

As more beneficiaries are choosing to enroll in managed care, there has been a lot of talk about fee-for-service being the "residual," as though it were somehow not important. However, even if we double the rate at which beneficiaries are moving into managed care in the short-term, the majority of beneficiaries will still be in fee-for-service. We must look for ways to improve our purchasing power. Over the past several years, private sector purchasers of health services have developed a variety of innovative ways they pay for health services. It is ironic that HCFA, the largest purchaser of health services in the U.S., has often been shackled by outdated statutory payment and administrative pricing provisions, which prevent us from adapting to today's marketplace.

Beneficiary-Centered Services - Given the pressures on the federal budget, it is critical that Medicare look beyond traditional purchasing strategies and scan the private industry horizon for new ideas. HCFA's "Beneficiary-Centered Purchasing Initiative" proposals do just that, applying lessons learned from the private sector and our demonstrations. If we are permitted by Congress to implement these proposals, we will have innovative purchasing arrangements which will be powerful tools to control Medicare spending.

For example, under our "Centers of Excellence" demonstration, Medicare achieved an average of 12 % savings for coronary artery bypass graft procedures performed, with no reduction in quality. Despite this success, we do not have the authority to make the Centers of Excellence program a permanent part of Medicare. Similarly, while other purchasers of health care services are successfully using disease and case management services to selectively provide services for enrollees with specific conditions (e.g. diabetes, congestive heart failure), we do not have this kind of authority under Medicare fee-for-service. The Office of Inspector General reports indicate that Medicare is paying far more for medical supplies and DME than other federal purchasers such as the Veteran Administration. Nevertheless, Medicare lacks authority to use competitive bidding to establish payment rates. I urge Congress to re-examine these issues and give the Medicare program the flexibility to pay on the basis of special arrangements, as opposed to statutorily-determined, administered prices.

Post-acute Services - Expenditures for skilled nursing facility (SNF), home health, rehabilitation and long-term hospital services are among the fastest growing components of Part A and total Medicare spending. These services are often referred to as "post-acute care services," even though in some cases these services are delivered without a prior hospital stay. The increase in expenditures for post-acute care providers is due to demographic changes and improvements in the delivery of medicine that allow more care to be delivered in non-hospital settings. However, our prospective payment system for hospitals provided the incentives for hospitals to discharge patients more quickly, also fueling the growth in post-acute care spending. In addition, this practice may cause Medicare to pay twice for care -- once for the initial hospitalization, and again for care in the post-acute settings.

The President's budget includes a proposal to end these double payments. We propose to limit the definition of a discharge, for payment purposes, to discharges from the hospital to home. All other discharges, including those to SNFs and rehabilitation hospitals, will be considered "transfers." We are also looking to develop better integrated and more flexible financing and delivery systems. These systems will help meet the needs of those Medicare beneficiaries with chronic conditions and disabilities who receive services from these post-acute care providers. The goal is to make the system of services "beneficiary-centered," where the needs of the patient, rather than the classification of the provider, determine what services are provided and how they are reimbursed. In the interim, we will move to prospective payment systems to assert greater control over post-acute spending.

Beginning in July 1998 and phased in over 4 years, we propose to implement a prospective payment system for SNFs, which will include payment for all costs related to SNF care (routine, ancillary and capital). SNFs will be paid a prospective rate per day of care, which will be adjusted by a case-mix index to appropriately reflect the resources used by Medicare patients. A prospective payment system that incorporates all costs will reduce incentives for over-utilization of ancillary costs that has been the primary reason for the rapid expenditure growth we have seen in the past few years.

We are also proposing to implement a prospective payment system for home health agencies (HHAs). Beginning in 1999, we will pay HHAs a prospective rate based upon the characteristics of the patients it serves, not on how many services it provides. Because we cannot continue to allow expenditure growth at current levels, we are also proposing to implement additional cost limits until we can implement this prospective payment system. Effective FY 1998, we will reduce the current cost limits and introduce a new per beneficiary per year limit. The Administration is also proposing a series of policy changes to prevent excessive and inappropriate billing for home health care services, which I will describe further when I discuss our proposals for stemming fraud and abuse. In addition, the Administration is also proposing to reallocate some of the home health financing to Part B to restore the post-acute care nature of Part A, as described in the next section.

While modernizing our payment methods for purchasing health care services for beneficiaries is an essential step toward modernization, we must also modernize the way we purchase administrative services. The President's budget contains a proposal that would end the requirement that all Medicare contractors (that is, carriers and intermediaries) perform all Medicare administrative activities. It gives HCFA the tools to take advantage of innovations and efficiencies in the private sector when it comes to utilization review, beneficiary and provider services, and claims processing. It builds upon the authority granted in the Health Insurance Accountability Act (HIPAA), where payment integrity activities (such as audits) could be separately contracted. This provision will also allow us to use the same competitive requirements that apply throughout the government when awarding new contracts, and would allow us to expand our pool of potential contractors beyond insurance companies to other entities that may be well qualified to do the work.

6 - *INTEGRATED QUALITY MANAGEMENT*

The President's budget will provide authority for HCFA to develop an integrated quality management system that will unify HCFA's quality assurance activities. Our current quality assurance activities are focused on minimum standards rather than the goal of achieving the best practicable health outcomes for beneficiaries. This new authority will allow us to assess the overall quality of care beneficiaries are receiving, and to require that care be effectively coordinated among different settings, rather than site by site as in our current system. As we move to require managed care plans to assess the overall quality of care they are providing to beneficiaries, we should be able to make the same determinations for beneficiaries who remain in fee-for-service Medicare.

7 - *IMPROVING ACCESS IN RURAL AREAS*

The character of the American experience was formed in great part by frontier and rural communities, yet over the past century we have become a largely urban society. Almost 200 million (75%) Americans live in urban and suburban areas, compared with only 60 million (25%) Americans living in rural areas. This has a profound impact on the type and availability of health care services as advancing technology requires ever more costly, and often non-portable, medical equipment. Additionally, there is the long-standing problem of enticing physicians and other health care providers to live and practice in rural areas.

This Administration continues to promote Medicare reforms that strengthen health care in rural America. For example, our plan will expand the extremely successful Rural Primary Care Hospital program to all 50 states. To ensure that the 10 million Medicare beneficiaries living in rural areas do not become second-class citizens in terms of access to health care, our plan updates the payment for Sole Community Hospitals, improves the Rural Referral Center program, and reinstates the Medicare Dependent Hospital program to provide resources to those rural hospitals that need it most.

EXTENSION OF MEDICARE SOLVENCY INTO 2007

Under present law, the Hospital Insurance Trust Fund would be depleted early in 2001, based on the Board of Trustees' intermediate estimates. The President's budget proposals would postpone depletion by another 6 years, so that the Fund could operate satisfactorily throughout the next 10 years. This extension will leave us time to tackle imminent fiscal problems precipitated by retiring baby boomers. Savings will be achieved through a combination of scored savings from reductions in payments to hospitals, home health agencies, skilled nursing facilities, and managed care plans, and through a reallocation of certain home health services to Part B.

MODERATING MEDICARE'S RATE OF GROWTH

The President's budget includes explicit proposals to achieve $100 billion in savings over the next 5 years. Medicare per capita spending growth over the next five years (1997-2002) will slow from the current projected rate of 7.4% to 5.3%. In 2002, this will lower our average per capita spending from $7,800 to $7,100. These savings come from substantial reductions in payments to providers.
[CHART # 4 - PRESERVING AND MODERNIZING MEDICARE]

Hospitals - We propose a series of hospital savings proposals, including a reduction in the hospital PPS update of 1.0 percentage point each year to account for increases in productivity, an extension of the reduction in capital payments from OBRA 90, reforms to the direct payment for medical education to reduce the growth of hospital-based residents and encourage more training in primary care, and reductions in the indirect medical payment to more closely reflect the cost of teaching activities. In addition, we propose to use a more up-to-date base year in calculating payments to PPS-exempt hospitals, to set ceilings and floors for these hospitals's target rates, and to reduce the annual update to payments and cut capital payments for PPS-exempt hospitals. Including our proposed moratorium on new long-term care hospitals, these proposals result in $33 billion in savings from hospitals over 5 years.

SNF and Home Health - As I described earlier, we will be moving to case-mix adjusted prospective payment systems for these providers. These payment systems will incorporate payment reductions equal to $7 billion for SNFs and $14 billion for home health agencies (HHAs).

Physicians - We propose to establish a single conversion factor for payments under the physician fee schedule and to reform the method for updating physician fees. By creating incentives to control physician services in high-volume inpatient settings and to make a single payment for surgery where an assistant-at-surgery is used, costs will be reduced. We also propose to expand the settings in which direct payment is made to physician assistants, nurse practitioners and clinical nurse specialists to include home and ambulatory settings. Medicare currently does not have an expansive outpatient drug benefit, though there is coverage of certain kinds of outpatient drugs. Our proposed plan will eliminate the mark-up charged by physicians and suppliers, limiting payments to acquisition costs subject to a limit. In addition to eliminating the current statutory x-ray requirement to determine the need for a service, we also propose to improve access to chiropractic services. These proposals will result in savings of $7 billion over 5 years.

FRAUD AND ABUSE

The President's budget contains a number of proposals to reduce waste, fraud and abuse in the Medicare program. Among these proposals are provisions to require insurance companies to report the insurance status of beneficiaries to ensure that Medicare pays appropriately. In addition, we have several proposals to prevent excessive and inappropriate billing for home health services. We are proposing to close a loophole in the current payment calculation by linking payments to the location where care is actually provided, rather than the billing location. When we implement the PPS, we will eliminate HHA periodic interim payments (PIPs), which were originally established to encourage HHAs to join Medicare by providing a smooth cash flow. Since over 100 new agencies join Medicare each month, inducements are no longer needed. We will develop more objective criteria for determining the appropriate number of visits per specific condition, so that we can prevent excessive utilization.

Finally, the President's budget calls for the repeal of several provisions in the HIPAA that could severely hamper our ability to fight fraud and abuse. First, the President is proposing to eliminate the broad new exception to the anti-kickback statute when providers are at "substantial financial risk." These terms are undefined and somewhat broad. Additionally, the Congressional Budget Office assigned a considerable cost to this provision because it could be easily abused by those wishing to profit from referrals. Second, the President is proposing to eliminate the requirement that advisory opinions be issued in response to specific requests as to how certain business arrangements may or may not be considered to violate the anti-kickback laws. This provision will severely hamper the government's ability to prosecute fraud, is impractical because it is difficult if not impossible to determine intent based on the submission of the requestor, and requires enormous resources to implement. Third, the President is proposing to reinstate the "reasonable diligence" standard. HIPAA eliminated the current standard for use of reasonable diligence and made providers subject to civil monetary penalties only if they acted with deliberate ignorance or reckless disregard.

CONCLUSION

We have looked beyond the immediate concerns of budget reductions and sought to keep our sights on the long-term goal, which is safeguarding the vitality of the Medicare program. As our Nation evolves into a society with greater numbers of the elderly and infirm, we must preserve Medicare as a strong and vital program. The President's budget modernizes Medicare, extends the solvency of the Hospital Insurance Trust Fund by ten years, reduces the rate of growth in Medicare spending, and contributes to a balanced budget in 2002. It is essential that we protect Medicare, and our payment reforms and strategies will ensure that Medicare is a sound investment our Nation's health security.

Modernizing Medicare

- New Benefits
  - + Diabetes education
  - + Improved mammography benefits
  - + Colorectal cancer screening
  - + Increased payment for vaccines with no cost-sharing
  - + Respite benefit for Alzheimer's patients

- Beneficiary Protections
  - + Hospital outpatient coinsurance reform
  - + Part B late enrollment surcharge reform
  - + Improved financial protections for managed care enrollees

- Prudent Purchasing
  - + Centers of excellence
  - + Competitive bidding
  - + Global payment for selected services
  - + Inherent reasonableness authority
  - + Post-acute services payment reform

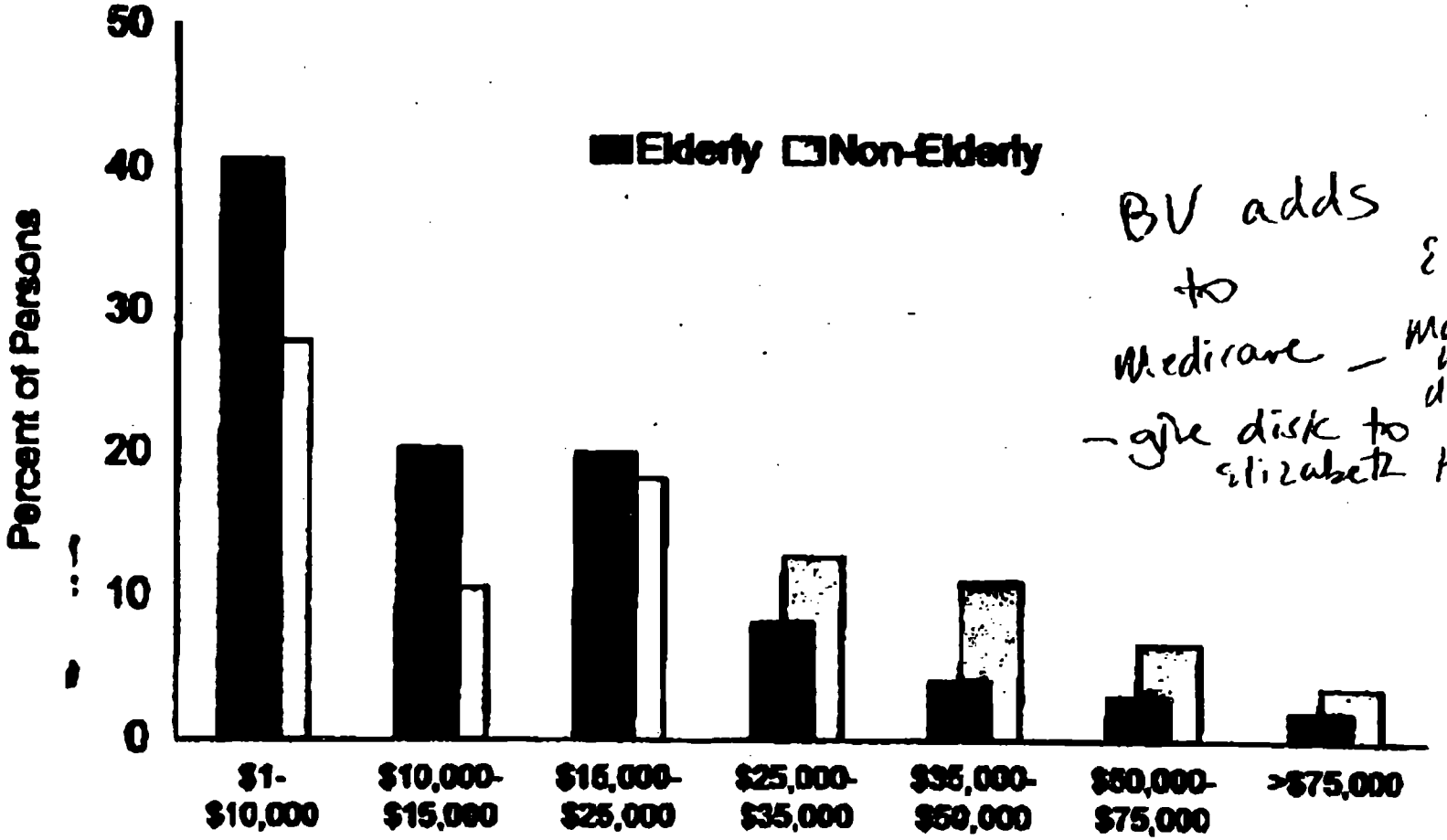
- Improving Choices
  - + Expanded managed care options
  - + Annual open enrollment for Medigap and managed care plans
  - + Comparative information on all choices
  - + Medigap community rating
  - + Medigap pre-existing condition refo
  - + Standardize additional benefit packs
  - + Revise managed care payment

Sec BU

Chart #-1

INCOMES OF THE ELDERLY AND THE NONELDERLY, 1995

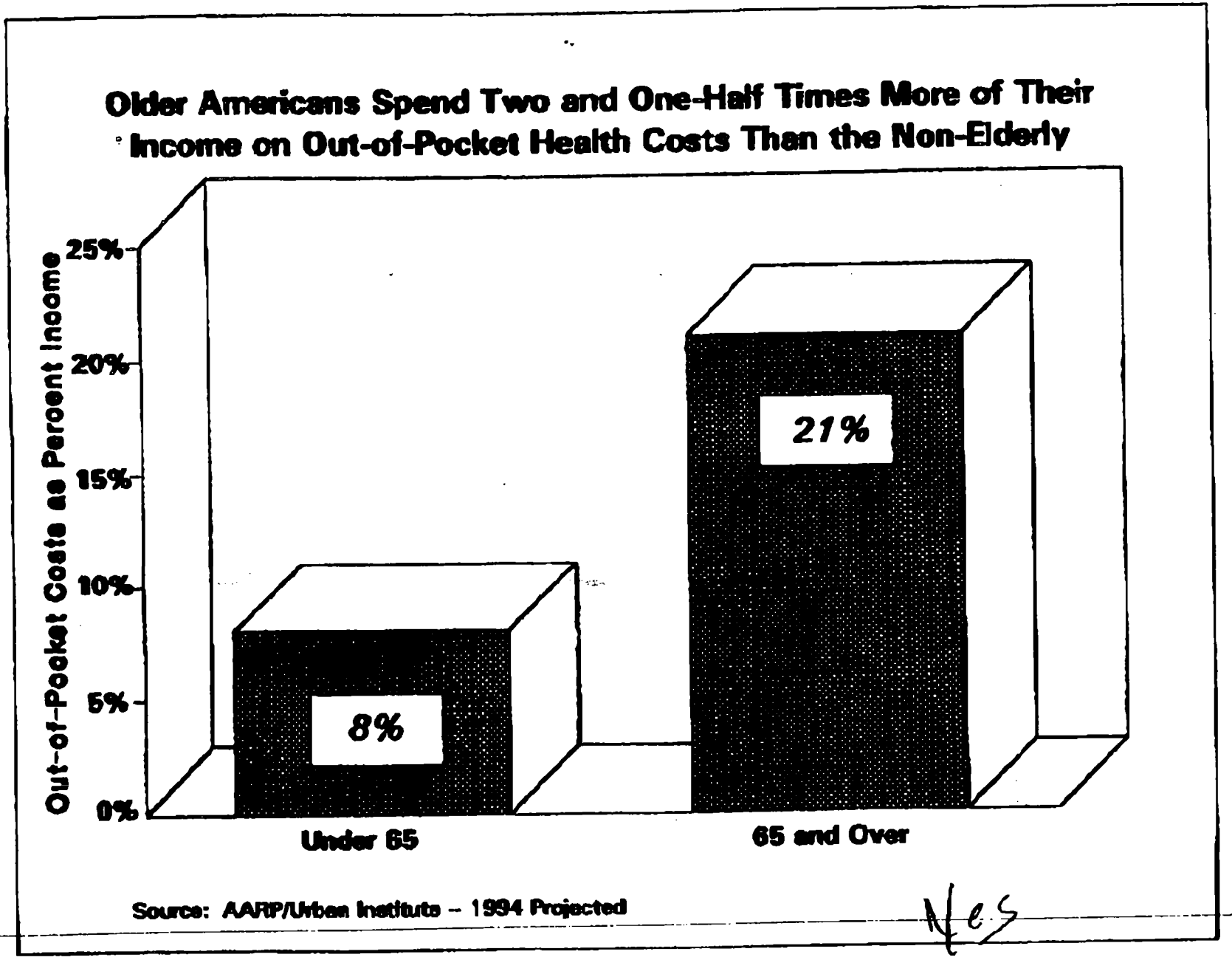
Only 9% of the Elderly Have Incomes Above $35,000



BV adds to Medicare — E'er + Margie has data — give disk to Elizabeth Hanford

Source: U.S. Department of Commerce, Bureau of the Census, 1996.

CHART #2

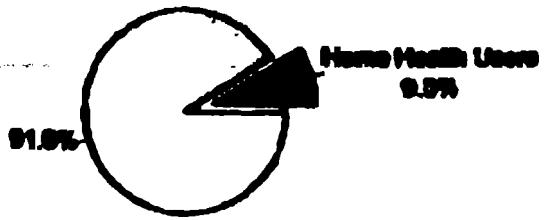


Yes

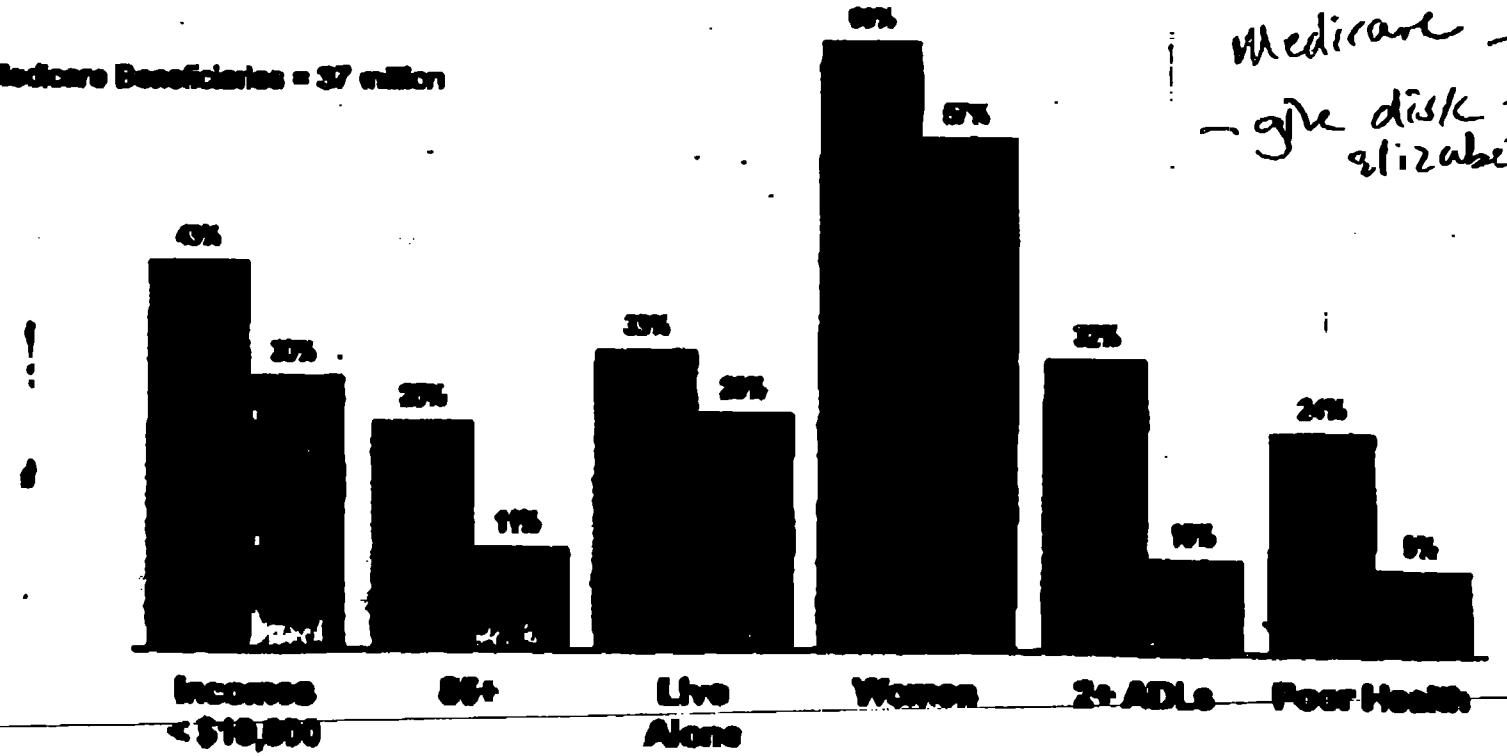
See BV

CHART #3

Characteristics of Medicare Home Health Users



Total Medicare Beneficiaries = 37 million



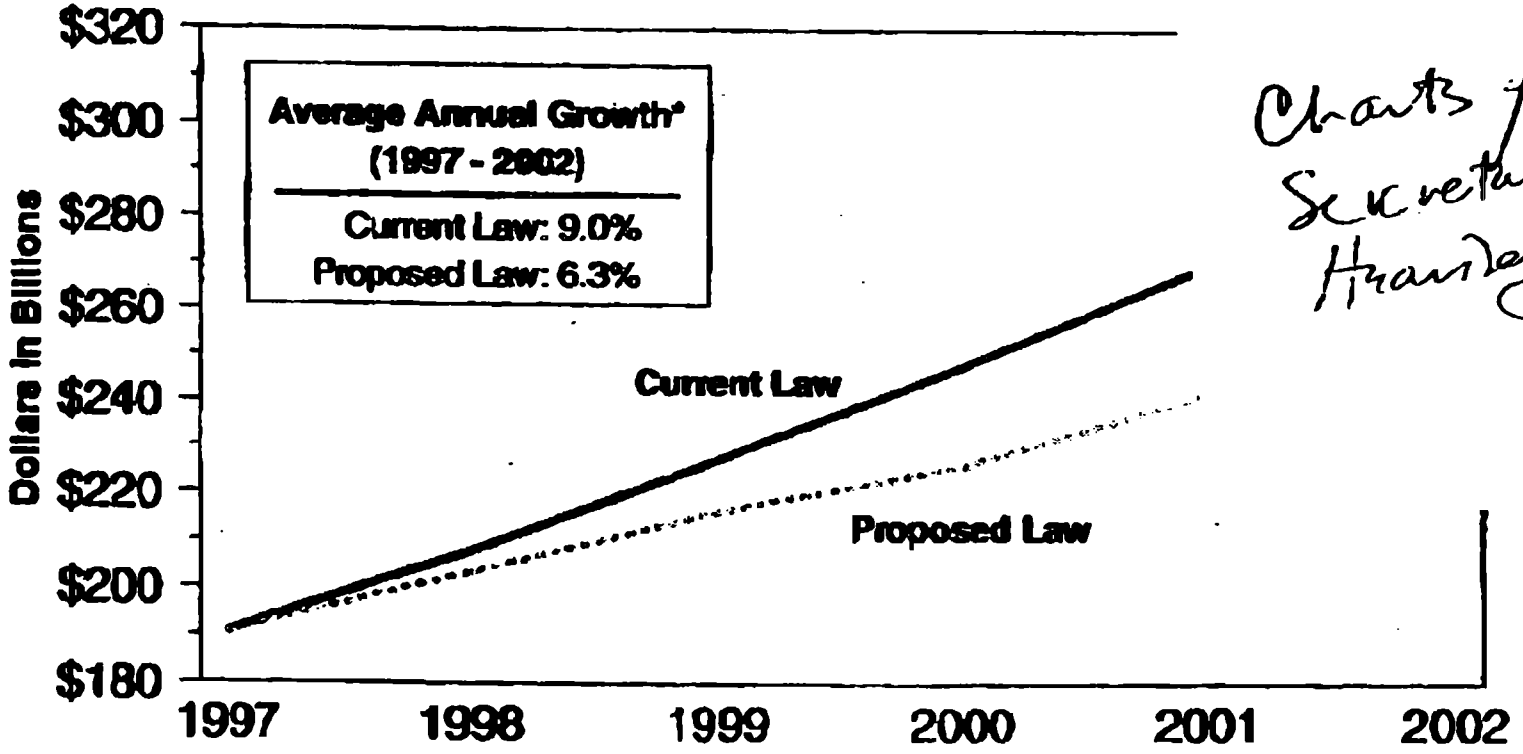
Source: HCFA, Medicare Current Beneficiary Survey.

BV adds to Medicare — Medigap info
— give disk to Elizabeth Hargrave
Ellen +

CHART # 4

Preserving and Modernizing Medicare: 1997 - 2002

Current Versus Proposed Law



Charts for Secretary's Hearing

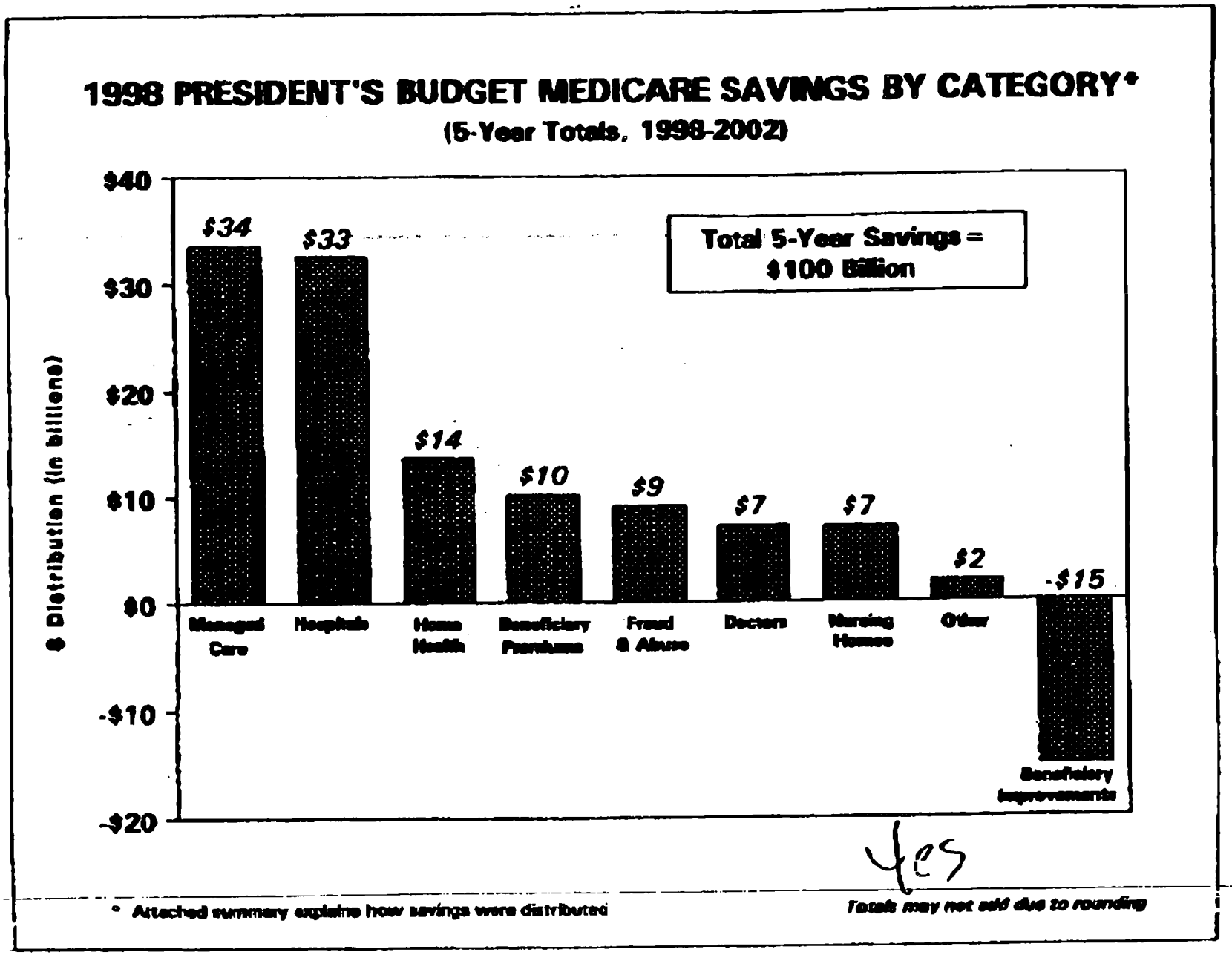
*Benefits Spending, Net of Offsetting Receipts

Source: 1998 President's Budget

YES

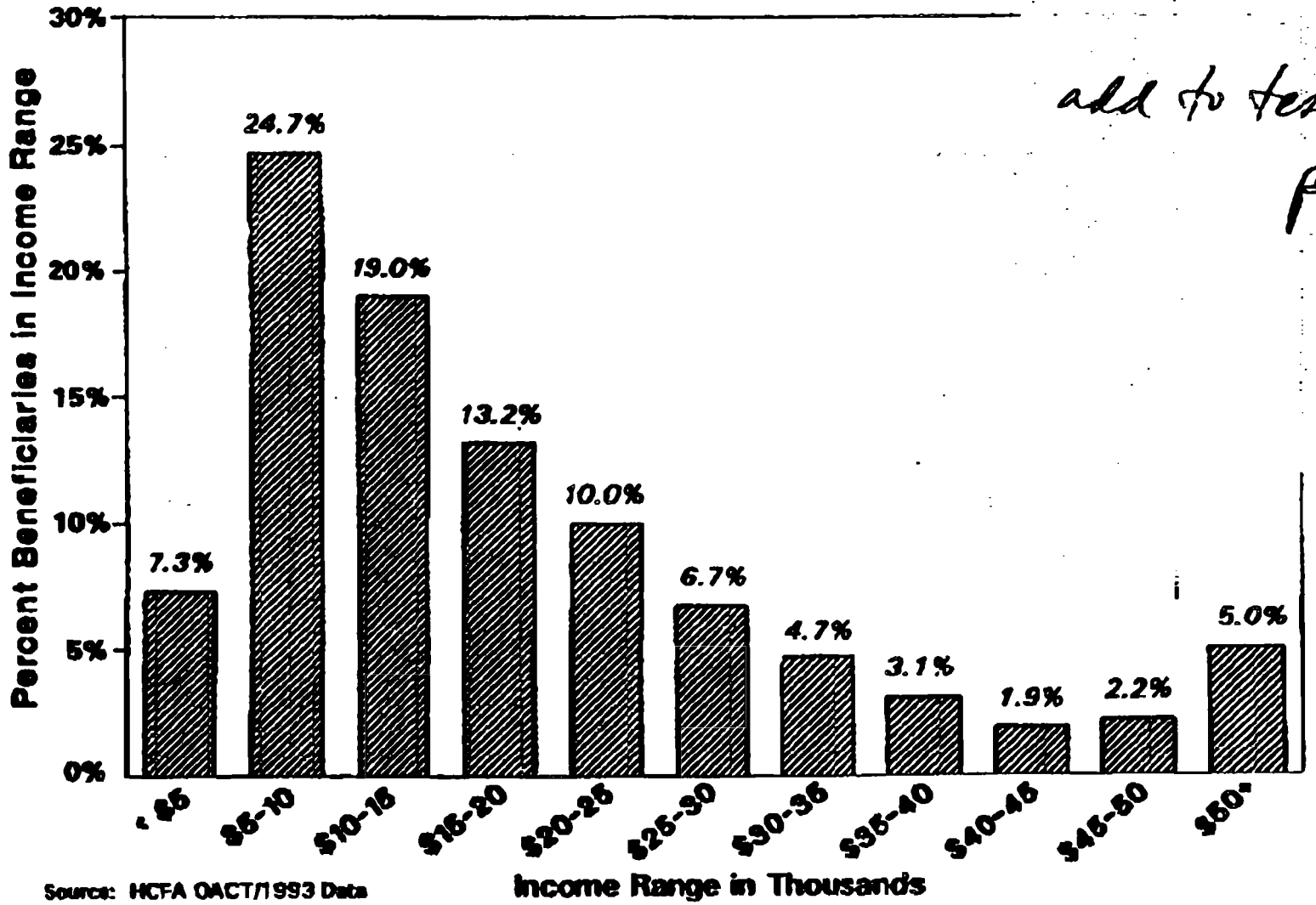
Sec BV

CHART #5



YES

Almost 75 Percent of Medicare Beneficiaries Have Incomes Under $25,000



add to testimony pkg.

* household income footnote

See BV

Yes

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division

Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

URGENT

URGENT

FROM: Melinda Haskins **395-3923**

DATE: 2/11/97 **TIME:** 10:30 a.m.

Pages sent (including transmittal sheet): 17

COMMENTS: Here is the proposed OMB passback on the HHS (Golden) testimony. Please review and comment ASAP.

[Note: Bruce and Elena and Ken Apfel also have a copy.]

TO: Diana Fortuna

Lyn Hogan

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

Draft Passback

DRAFT

TESTIMONY

OF

OLIVIA A. GOLDEN
ADMINISTRATION FOR CHILDREN AND FAMILIES
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HUMAN RESOURCES
UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 13, 1997

Members of the Subcommittee,

I am pleased to appear before this Subcommittee today to discuss two important initiatives from the President's budget that you have identified as being of particular interest -- the President's initiatives on adoption and welfare to work. I would also like to briefly discuss the Administration's proposals addressing Medicaid and Food Stamp benefits for qualified aliens, so that you have a complete picture of the President's efforts to restore fairness to the Federal safety net programs.

My testimony will focus primarily on the adoption initiative ~~since that is the issue I am most personally involved with and since it is critically important to the Administration for Children and Families~~. I am accompanied today by xxx from the Department of Labor, who will respond to your questions about Welfare-to-Work.

The President's budget for FY 1998 addresses the needs of children and families in multiple ways that we believe will strengthen families, move people from welfare to work and increase self-sufficiency. The areas you have identified for this hearing are certainly important to this mission. The Welfare-to-Work initiative reaffirms and strengthens the work commitment of last year's landmark welfare reform legislation and responds to what the President cites as "our moral obligation, to make sure that people who now must work can work." The adoption initiative focuses special attention on the needs of some of our most vulnerable citizens -- children languishing in foster care -- who deserve safe and permanent families. I will address each initiative in a few moments.

First, however, I would like to touch on our progress in implementing welfare reform. I believe it is the cornerstone to realizing our key goals of work, responsibility and protecting children.

I will close my testimony by briefly addressing problems in the welfare reform legislation that are harmful to immigrants and that have nothing to do with promoting the welfare reform goals of moving people from welfare to work. As the President said in his State of the Union address with respect to his proposed strategy to address these problems, "To do otherwise is simply unworthy of a great nation of immigrants."

The President's Budget proposes to continue to provide SSI and Medicaid to vulnerable categories of legal immigrants, especially children and those who become disabled after entry.

Welfare Reform Implementation

The Administration for Children and Families is responsible for administering several of the programs most affected by the welfare reform legislation, including the new Temporary Assistance for Needy Families (TANF) program, child care programs for families on welfare and other low-income working families, and the child support enforcement program. States and the Federal government alike are promptly implementing each of these major pieces of the Act and we are encouraged by the early progress being made.

So far, we have received 42 TANF plans from states, territories, and tribes and 35 have been certified as complete. Many state legislatures are just now coming into session and will be addressing the TANF plans, and we expect new plans from the remaining states and amendments to plans already submitted before the July 1, 1997 implementation deadline.

Welfare reform provides States with great flexibility to ensure that welfare is a transitional system, rather than a way of life. Along with this new authority and flexibility, the new statute holds states more accountable for program performance. It includes a variety of provisions designed to ensure that states are moving people from welfare to work: penalties, performance-based funding, data collection and reporting, and research and evaluation.

On January 31, 1997, because of many states' requests for clarifications, we issued preliminary guidance concerning several issues of immediate concern, most notably the definition of which state expenditures count toward maintenance-of-effort. The guidance also addresses the definitions of "assistance," a key term in determining which expenditures are covered by certain rules, and "eligible families," a key term in determining which state resources count as maintenance-of-effort.

if necessary we will work with the States and Congress to develop legislation to ensure that flexibility

The Clinton Administration is committed to an effective implementation of this historic welfare reform law that transforms the welfare system into one with tough work requirements. We have a great deal of confidence in the states, and we believe that they will use the flexibility in the law to strengthen the focus on work. ~~At the same time, the Department will use all its administrative authority to prevent states from using their flexibility to undercut the intent of the statute.~~ We will collect all the information we can on how the states are using their dollars and we will take all the administrative actions in our power to ensure that state policies focus on work. We will also work with you and the Governors ~~to ensure that the work participation rates in the statute take into account overall State work effort, across State and Federal programs.~~ in a bipartisan fashion to ensure that each State's overall work effort meets the statute's work participation requirements. Specifically, we will seek statutory language making it clear that the calculation of whether a state has met the applicable participation rate shall take into

and do not result in costs to the Federal Government due to the loss of child support collections.

recognize the States' success in placing participants in both TANF and maintenance of effort programs in work activities.

As part of the development of TANF policy and guidance, we have met and continue to meet with state and local administrators and legislators and their national representatives. We also have met with advocates, and representatives of non-profit organizations and foundations, organized labor, and business organizations. These consultations have helped us to identify issues, such as the one described above, and to ensure that a wide range of perspectives are considered in the development of policy.

During these meetings we have also heard about the critical importance of child care in enabling people to move from welfare to work. We were pleased that the new law provided a substantial increase in child care funding and increased flexibility for states to design an integrated child care system to serve both families on welfare and low-income working families. We refer to the newly integrated system as the Child Care and Development Fund (CCDF). ACF moved quickly to implement the child care program changes, which became effective October 1, 1996.

Our Child Care Bureau has taken a number of steps to inform prospective grantees and other interested parties about the CCDF and to ensure the earliest possible flow of the new funds in order to provide continuity between the old and new programs. We issued new mandatory and matching funds as soon as they became available and published early policy guidance requested by states. ~~We designed new streamlined grantee plan formats and new data collection instruments.~~ We have held consultations with grantees and other organizations. We now are developing regulations and financial reporting forms and other data collection forms. We also are planning for the FY 1998 grant cycle, for which states and tribes will submit applications by July 1, 1997.

We are also proud of the progress states have made in child support enforcement. In 1996, we collected a record of almost $12 billion in child support payments, and the comprehensive provisions in the welfare law are projected to increase child support collections by an additional $24 billion over 10 years.

Implementation of many of these new provisions will require the enactment of state laws. Effective dates of the new requirements vary, but typically fall within 1 to 2 years of enactment. Therefore, full implementation of the child support provisions will take place over time.

Nevertheless, many states already have implemented some of the new federal requirements. For example, in 1995 the President urged all states to implement license revocation programs. Today 43 states have done so. In addition, 35 states recently have enacted the Uniform Interstate Family Support Act, and 26 states have adopted some form of reporting new hires.

At the federal level, we have made great progress in making the expanded Federal Parent Locator Service (FPLS) a reality and we anticipate meeting the statutory deadline. Since the enactment of welfare reform, we have entered into contracts with several nationally recognized and respected vendors to help us design and develop the expanded FPLS, manage the project and enhance our quality assurance efforts, and assist us with providing training and technical assistance.

The federal Office of Child Support Enforcement is also providing technical assistance to states in implementing the other child support provisions in welfare reform. We are conducting broad consultation and outreach to program stakeholders to ensure that the promise of the legislation -- a strong child support enforcement program -- is realized.

With respect to the reforms affecting each of these programs, the Administration for Children and Families is committed to working closely with the Congress, the States and localities to ensure that families receive the supports and encouragement they need to move forward with their lives, to engage in work, and to support and nurture their children. I will now turn to the items from the President's budget that are the focus of your invitation -- the adoption and Welfare-to-Work initiatives.

The Adoption Initiative

In his radio address to the nation on December 14th, the President set an ambitious national goal: to double, ~~the number of children from the foster care system who are permanently placed in families in 2002.~~ by the year 2002, the number of children from the foster care system who are adopted or permanently placed annually. ~~The President asked the Department of Health and Human Services to report to him by February 14 on our strategies for achieving this national goal. We will be transmitting the report to the President tomorrow.~~

In his directive to HHS on adoption, the President asked us to work with States to set numerical targets to benchmark improvement, provide technical assistance to help States in their efforts,

and recognize and reward States for their success with financial incentives. With respect to the latter, we will propose providing, beginning in FY 1999, a per child financial incentive to States for increases in the number of children adopted from the public child welfare system. As we envision it, the incentive structure would result in no net cost, since increased adoptions from the public system would reduce foster care costs. This approach represents another step toward focusing on outcomes for children and families in evaluating the effectiveness of our programs.

The President's FY 98 budget has requested $10 million to provide technical assistance to the States as they strive to find more children living and permanent homes. The President has requested an additional $10 million to provide funding to States to identify barriers to permanency and develop targeted strategies to find permanent homes for children who have been in foster care a particularly long time. Finally, he has requested $1 million for the Department of Health and Human Services to embark on a public awareness campaign to highlight the benefits of adoption and increase the number of adoptive families.

We are strengthening our efforts on adoption because of a growing consensus that we must engage in a more concerted effort to move children to adoption or another permanent family arrangement when they are unable to return home. We know that some children are in foster care far too long awaiting adoption. Last winter, I visited the White House with a teenager who had been in several foster placements over the course of many years. She described the longing that she felt to have a family of her own, but her hopes were fading as she got older and no family could be found. I am pleased to report that this young woman was adopted last year, partially as

a result of the attention that her plight received. However, she represents thousands of other children in the public child welfare system who still face multiple barriers to permanence.

Currently, 100,000 of the 450,000 American children in foster care will not be able to return home. Yet, in 1995, only 20,000 children were adopted; another 7,000 children were placed in permanent guardianships. There are multiple barriers to permanence for children in foster care which include a system overwhelmed with serious cases, procedural delays in agencies and the courts and a dearth of potential adoptive families. Underlying and compounding these barriers is the complexity and gravity of the placement decisions that must be made for each child and family in crisis. The President emphasized in his directive that placing children in nurturing families is a responsibility that requires a commitment from Federal, State, and local governments, as well as community, business, and religious groups.

States and communities all over the country are implementing innovative techniques, as we learned when we consulted with hundreds of State, county, and tribal leaders, foster care and adoption professionals, judges, foundations, and intergovernmental organizations in developing our report to the President. They have asked us to explore further with them innovative practices like concurrent planning for children in care, family mediation, and voluntary relinquishment counseling for parents.

We will build on this momentum and continue to look for ways to

- o reduce barriers to permanency in Federal law and regulations through bipartisan collaborative efforts

- o shorten the time required to move children to permanence

- o reduce procedural barriers and promote practices that move children to permanency more quickly by examining a number of policy issues, such as reasonable efforts to ensure permanency and policies on timing and purpose of dispositional hearings.

The recent Congressional actions, the President's initiative, the willingness to work together at all levels of government and innovations in the field make our goals more achievable. We look forward to working with the Congress to realize these goals for children.

Welfare-to-Work Initiative

Insert (A)

The Welfare to Work Jobs challenge proposed by the President is designed to help States and cities move a million ~~of the hardest to employ welfare recipients into lasting jobs by the year 2000~~ welfare recipients off the rolls by the year 2000. It provides $3 billion over 3 years in mandatory financing through the Department of Labor ~~to create new jobs and place individuals in them~~ for job placement and job creation. States and cities can use these funds to provide subsidies and other incentives to encourage private business to hire welfare recipients.

INSERT (A)

The essence of the new welfare law is to shift the whole notion of welfare from dependency, to independence through work. It would be hard to overstate how significant this change is in philosophy from prior decades, and how enormous the positive results can be for poor people. But for the poor to realize the full benefits of the Act, at least four key things must happen:

1. Welfare recipients must accept their personal responsibility to prepare for, seek, and accept work instead of welfare;

2. States and cities must take full advantage of the opportunities it offers them to implement law by fundamentally changing the approach of their administering agencies from the focus on dependency to the focus on helping people prepare for, find, take, and hold jobs;

3. Private business, ~~churches~~ religious organizations and others must respond enthusiastically to the President's challenge to create jobs;

4. Congress must join with the President to enact two additional pieces of law -- (a) the $3 billion welfare to work challenge fund, and (b) the enhancements to the Work Opportunity Tax Credit.

With these four elements, States, cities and welfare recipients can devise a coherent, State-by-State, welfare-to-work strategy, and make real the promise of welfare reform. This Administration is dedicated to the realization of that promise.

The Jobs Challenge will make it possible for many welfare recipients to do what most want to -- work. It will empower individuals with the skills and information necessary to get ~~and keep~~ e jobs in the private sector and keep them. To be successful, it requires strong private sector support. The President recently suggested that communities should use "employment councils" like the one in Kansas City to help in meeting the requirements of welfare reform. Under the Job Training Partnership Act, 640 similar councils in place across the country engage over 10,000 private sector volunteers in overseeing the training and placement into jobs of welfare recipients, other low income adults and youth, as well as dislocated workers. We anticipate that States and communities will actively engage these councils in meeting the Jobs Challenge.

placement and job,

It is now widely recognized that a more targeted job creation measure is needed to supplement the TANF Block Grant if we are to make welfare reform work. The Jobs Challenge is intended to meet this need. ~~Details of the proposal will be available in the early spring, and~~ we look forward to working closely with the Congress in exploring ways to assist States and localities in helping welfare recipients who can't find jobs on their own transition from welfare into real private sector jobs.

Insert B

Other tools are available through the Labor Department to provide further incentive to create new job opportunities for long-term welfare recipients. These tools include the Work Opportunity Tax Credit (WOTC) -- administered by the State Employment Security Agencies -- for employers who employ welfare recipients. The President proposes to extend the credit for

Insert B

The President's FY98 Budget would also greatly enhance and target the Work Opportunity Tax Credit to provide powerful, new private-sector financial incentives to employers to create jobs for long-term welfare recipients. The enhanced Work Opportunity Tax Credit would allow employers to claim a 50-percent credit on the first $10,000 a year of wages, for up to two years, for workers that they hire who were long-term welfare recipients. For the purpose of determining the amount of the credit, employers' wages could include the cost of training, medical assistance, and child care. In addition, the President proposes to expand the existing tax Work Opportunity Tax Credit to include able-bodied childless adults aged 18 to 50, who, under the Administration's Food Stamp proposal, would face a more rigorous work requirement in order to continue to receive Food Stamps.

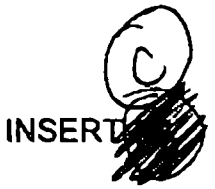
current targeted groups through September 30, 1998. He also proposes to expand the credit to include adults age 18 to 50 who are subject to the rigorous work requirement under the Food Stamp legislative proposal.

In addition, the Administration proposes a targeted welfare-to-work tax credit designed to create new job opportunities for long-term welfare recipients. The credit would enable employers to claim a 50 percent credit on the first $10,000 of annual wages paid to long-term recipients. The credit could be claimed for up to two years and employers would be able to treat education and training assistance, health care, and dependent care as eligible wages. The credit would be available for wages paid or incurred effective the date of enactment through September 30, 2000.

Insert

Finally, today you will be hearing from the Social Security Administration about one of the Administration's key proposals to satisfy the President's commitment to modify provisions in the landmark welfare reform law which had nothing to do with moving people from welfare to work.

In addition to restoring basic disability benefits, the Administration is proposing additional actions to restore equity for legal immigrant children and those who become disabled after entry. The HHS budget includes funding to restore Medicaid benefits to disabled children, and to legal immigrants who are either children or disabled adults -- people who cannot work.



Another major focus for the Administration is to change parts of the welfare reform law that have nothing to do with welfare reform. When the President signed the Welfare Reform bill he made clear his disappointment with the harsh benefits to immigrants provisions in the bill. The President stated:

"My Administration supports holding sponsors who bring immigrants into this country more responsible for their well-being. Legal immigrants and their children, however, should not be penalized if they become disabled and require medical assistance through no fault of their own."

The President's FY 1998 budget makes good on his promise to correct provisions that were included to save money, and which burden States and punish children and the disabled. We are pleased that the governors, in an NGA resolution several weeks ago, agreed -- we must not balance the budget on the backs of States or legal immigrants.

Today, you will also be hearing from the Social Security Administration about this key Administration proposal. I would also like to make a few points about why this action is so important.

The welfare law denies most legal immigrants access to fundamental safety net programs unless they become citizens -- even though they are in the U.S. legally, are working and paying taxes and are responsible members of our communities. The Administration has always supported making individuals who encourage their relatives to emigrate to the United States more responsible for the immigrant's well being. However, as a nation, we should not turn our backs on anyone who has lost their ability to earn a living due to injury, disease or illness. The Nation should protect legal immigrants and their families -- people admitted as permanent members of the American community -- when they suffer accidents or illnesses that prevent them from earning a living. Consequently, the budget proposes to make legal immigrants who become disabled after entering the United States eligible for SSI and Medicaid. This proposal would allow ~~over~~ 320,000 legal immigrants to receive SSI and Medicaid benefits.

The budget would also provide poor immigrant children the same Medicaid health care coverage low income citizen children receive. These children are permanent members of our nation and it is in our self interest to provide them with the same quality of health care as other children.

The budget would lengthen the five year exemption for refugees from the ban to seven years in order to give them a more appropriate amount of time to naturalize. The United States admits refugees and asylees into this country on a humanitarian basis. It is a matter of simple decency to provide assistance for this population while they adjust to their new circumstances.

The budget also creates an exemption for refugees that is more sensitive to the needs of this group. Welfare reform exempted refugees and asylees from the benefit restrictions for their first five years in the country. The budget would extend the exemption from 5 to 7 years to provide a more appropriate amount of time for refugees and asylees to become citizens.

In addition, the Administration is proposing to delay the prohibition against legal immigrants receiving Food Stamps. The Administration proposes to delay the ban on Food Stamps for legal immigrants until the end of FY 1997 in order to give legal immigrant families, elderly and disabled more time to naturalize.

Conclusion

In closing, I would like once again to thank you for your support on behalf of children living in poverty and children in our nation's child welfare system. I look forward to our continued work together as we seek to realize the goals of independence for every family and safety, permanence, and well-being for every child.

My colleagues and I would be happy to answer any questions you have at this time.

URGENT

Total Pages: 15

LRM ID: MDH7

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

Friday, February 7, 1997

LEGISLATIVE REFERRAL MEMORANDUM

TO:	Legislative Liaison Officer - See Distribution below
FROM:	Janet R. Forsgren (for) Assistant Director for Legislative Reference
OMB CONTACT:	Melinda D. Haskins
	PHONE: (202)395-3923 **FAX:** (202)395-6148
SUBJECT:	HHS Proposed Testimony on Welfare-Related Proposals in the President's FY98 Budget
DEADLINE:	**NOON Monday, February 10, 1997**

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. **Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.**

COMMENTS: The attached HHS (Golden) testimony on the FY98 Budget proposals for welfare programs is scheduled to be delivered to the House Human Resources Subcommittee on Thursday, February 13th. **This deadline is firm.**

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LRM ID: MDH7 **SUBJECT:** HHS Proposed Testimony on Welfare-Related Proposals in the President's FY98 Budget

RESPONSE TO
LEGISLATIVE REFERRAL
MEMORANDUM

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or

(2) sending us a memo or letter

Please include the LRM number shown above, and the subject shown below.

TO: Melinda D. Haskins Phone: 395-3923 Fax: 395-6148
Office of Management and Budget
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ _____ ____ (Date)

_____ _____ _____ _____ (Name)

_____ _____ _____ _____ (Agency)

_____ _____ _____ (Telephone)

The following is the reponse of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____ _____

_____ FAX RETURN of _____ pages, attached to this reponse sheet

TESTIMONY

OF

OLIVIA A. GOLDEN
ADMINISTRATION FOR CHILDREN AND FAMILIES
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HUMAN RESOURCES
UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 13, 1997

Members of the Subcommittee,

I am pleased to appear before this Subcommittee today to discuss two important initiatives from the President's budget that you have identified as being of particular interest -- the President's initiatives on adoption and welfare to work. I would also like to briefly discuss the Administration's proposals addressing Medicaid and Food Stamp benefits for qualified aliens, so that you have a complete picture of the President's efforts to restore fairness to the Federal safety net programs.

My testimony will focus primarily on the adoption initiative since that is the issue I am most personally involved with and since it is critically important to the Administration for Children and Families. I am accompanied today by xxx from the Department of Labor, who will respond to your questions about Welfare-to-Work.

The President's budget for FY 1998 addresses the needs of children and families in multiple ways that we believe will strengthen families, move people from welfare to work and increase self-sufficiency. The areas you have identified for this hearing are certainly important to this mission. The Welfare-to-Work initiative reaffirms and strengthens the work commitment of last year's landmark welfare reform legislation and responds to what the President cites as "our moral obligation, to make sure that people who now must work can work." The adoption initiative focuses special attention on the needs of some of our most vulnerable citizens -- children languishing in foster care -- who deserve safe and permanent families. I will address each initiative in a few moments.

First, however, I would like to touch on our progress in implementing welfare reform. I believe it is the cornerstone to realizing our key goals of work, responsibility and protecting children.

I will close my testimony by briefly addressing problems in the welfare reform legislation that are harmful to immigrants and that have nothing to do with promoting the welfare reform goals of moving people from welfare to work. As the President said in his State of the Union address with respect to his proposed strategy to address these problems, "To do otherwise is simply unworthy of a great nation of immigrants."

Welfare Reform Implementation

The Administration for Children and Families is responsible for administering several of the programs most affected by the welfare reform legislation, including the new Temporary Assistance for Needy Families (TANF) program, child care programs for families on welfare and other low-income working families, and the child support enforcement program. States and the Federal government alike are promptly implementing each of these major pieces of the Act and we are encouraged by the early progress being made.

So far, we have received 42 TANF plans from states, territories, and tribes and 35 have been certified as complete. Many state legislatures are just now coming into session and will be addressing the TANF plans, and we expect new plans from the remaining states and amendments to plans already submitted before the July 1, 1997 implementation deadline.

Welfare reform provides States with great flexibility to ensure that welfare is a transitional system, rather than a way of life. Along with this new authority and flexibility, the new statute holds states more accountable for program performance. It includes a variety of provisions designed to ensure that states are moving people from welfare to work: penalties, performance-based funding, data collection and reporting, and research and evaluation.

On January 31, 1997, because of many states' requests for clarifications, we issued preliminary guidance concerning several issues of immediate concern, most notably the definition of which state expenditures count toward maintenance-of-effort. The guidance also addresses the definitions of "assistance," a key term in determining which expenditures are covered by certain rules, and "eligible families," a key term in determining which state resources count as maintenance-of-effort.

The Clinton Administration is committed to an effective implementation of this historic welfare reform law that transforms the welfare system into one with tough work requirements. We have a great deal of confidence in the states, and we believe that they will use the flexibility in the law to strengthen the focus on work. At the same time, the Department will use all its administrative authority to prevent states from using their flexibility to undercut the intent of the statute. We will collect all the information we can on how the states are using their dollars and we will take all the administrative actions in our power to ensure that state policies focus on work. We will also work with you and the Governors to ensure that the work participation rates in the statute take into account overall State work effort, across State and Federal programs.

As part of the development of TANF policy and guidance, we have met and continue to meet with state and local administrators and legislators and their national representatives. We also have met with advocates, and representatives of non-profit organizations and foundations, organized labor, and business organizations. These consultations have helped us to identify issues, such as the one described above, and to ensure that a wide range of perspectives are considered in the development of policy.

During these meetings we have also heard about the critical importance of child care in enabling people to move from welfare to work. We were pleased that the new law provided a substantial increase in child care funding and increased flexibility for states to design an integrated child care system to serve both families on welfare and low-income working families. We refer to the newly integrated system as the Child Care Development Fund (CCDF). ACF moved quickly to implement the child care program changes, which became effective October 1, 1996.

Our Child Care Bureau has taken a number of steps to inform prospective grantees and other interested parties about the CCDF and to ensure the earliest possible flow of the new funds in order to provide continuity between the old and new programs. We issued new mandatory and matching funds as soon as they became available and published early policy guidance requested by states. We designed new streamlined grantee plan formats and new data collection instruments. We have held consultations with grantees and other organizations. We now are developing regulations and financial reporting forms. We also are planning for the FY 1998 grant cycle, for which states and tribes will submit applications by July 1, 1997.

We are also proud of the progress states have made in child support enforcement. In 1996, we collected a record of almost $12 billion in child support payments, and the comprehensive provisions in the welfare law are projected to increase child support collections by an additional $24 billion over 10 years.

Implementation of many of these new provisions will require the enactment of state laws. Effective dates of the new requirements vary, but typically fall within 1 to 2 years of enactment. Therefore, full implementation of the child support provisions will take place over time.

Nevertheless, many states already have implemented some of the new federal requirements. For example, in 1995 the President urged all states to implement license revocation programs. Today 43 states have done so. In addition, 35 states recently have enacted the Uniform Interstate Family Support Act, and 26 states have adopted some form of reporting new hires.

At the federal level, we have made great progress in making the expanded Federal Parent Locator Service (FPLS) a reality and we anticipate meeting the statutory deadline. Since the enactment of welfare reform, we have entered into contracts with several nationally recognized and respected vendors to help us design and develop the expanded FPLS, manage the project and enhance our quality assurance efforts, and assist us with providing training and technical assistance.

The federal Office of Child Support Enforcement is also providing technical assistance to states in implementing the other child support provisions in welfare reform. We are conducting broad consultation and outreach to program stakeholders to ensure that the promise of the legislation -- a strong child support enforcement program -- is realized.

With respect to the reforms affecting each of these programs, the Administration for Children and Families is committed to working closely with the Congress, the States and localities to ensure that families receive the supports and encouragement they need to move forward with their lives, to engage in work, and to support and nurture their children. I will now turn to the items from the President's budget that are the focus of your invitation -- the adoption and Welfare-to-Work initiatives.

The Adoption Initiative

In his radio address to the nation on December 14th, the President set an ambitious national goal: to double the number of children from the foster care system who are permanently placed in families in 2002. The President asked the Department of Health and Human Services to report to him by February 14 on our strategies for achieving this national goal. We will be transmitting the report to the President tomorrow.

In his directive to HHS on adoption, the President asked us to work with States to set numerical targets to benchmark improvement, provide technical assistance to help States in their efforts,

and recognize and reward States for their success with financial incentives. With respect to the latter, we will propose providing, beginning in FY 1999, a per child financial incentive to States for increases in the number of children adopted from the public child welfare system. As we envision it, the incentive structure would result in no net cost, since increased adoptions from the public system would reduce foster care costs. This approach represents another step toward focusing on outcomes for children and families in evaluating the effectiveness of our programs.

The President's FY 98 budget has requested $10 million to provide technical assistance to the States as they strive to find more children living and permanent homes. The President has requested an additional $10 million to provide funding to States to identify barriers to permanency and develop targeted strategies to find permanent homes for children who have been in foster care a particularly long time. Finally, he has requested $1 million for the Department of Health and Human Services to embark on a public awareness campaign to highlight the benefits of adoption and increase the number of adoptive families.

We are strengthening our efforts on adoption because of a growing consensus that we must engage in a more concerted effort to move children to adoption or another permanent family arrangement when they are unable to return home. We know that some children are in foster care far too long awaiting adoption. Last winter, I visited the White House with a teenager who had been in several foster placements over the course of many years. She described the longing that she felt to have a family of her own, but her hopes were fading as she got older and no family could be found. I am pleased to report that this young woman was adopted last year, partially as

a result of the attention that her plight received. However, she represents thousands of other children in the public child welfare system who still face multiple barriers to permanence.

Currently, 100,000 of the 450,000 American children in foster care will not be able to return home. Yet, in 1995, only 20,000 children were adopted; another 7,000 children were placed in permanent guardianships. There are multiple barriers to permanence for children in foster care which include a system overwhelmed with serious cases, procedural delays in agencies and the courts and a dearth of potential adoptive families. Underlying and compounding these barriers is the complexity and gravity of the placement decisions that must be made for each child and family in crisis. The President emphasized in his directive that placing children in nurturing families is a responsibility that requires a commitment from Federal, State, and local governments, as well as community, business, and religious groups.

States and communities all over the country are implementing innovative techniques, as we learned when we consulted with hundreds of State, county, and tribal leaders, foster care and adoption professionals, judges, foundations, and intergovernmental organizations in developing our report to the President. They have asked us to explore further with them innovative practices like concurrent planning for children in care, family mediation, and voluntary relinquishment counseling for parents.

We will build on this momentum and continue to look for ways to

- reduce barriers to permanency in Federal law and regulations through bipartisan collaborative efforts

- shorten the time required to move children to permanence

- reduce procedural barriers and promote practices that move children to permanency more quickly by examining a number of policy issues, such as reasonable efforts to ensure permanency and policies on timing and purpose of dispositional hearings.

The recent Congressional actions, the President's initiative, the willingness to work together at all levels of government and innovations in the field make our goals more achievable. We look forward to working with the Congress to realize these goals for children.

Welfare-to-Work Initiative

The Welfare to Work Jobs challenge proposed by the President is designed to help States and cities move a million of the hardest-to-employ welfare recipients into lasting jobs by the year 2000. It provides $3 billion over 3 years in mandatory financing through the Department of Labor to create new jobs and place individuals in them. States and cities can use these funds to provide subsidies and other incentives to encourage private business to hire welfare recipients.

The Jobs Challenge will make it possible for many welfare recipients to do what most want to -- work. It will empower individuals with the skills and information necessary to get and keep jobs in the private sector and keep them. To be successful, it requires strong private sector support. The President recently suggested that communities should use "employment councils" like the one in Kansas City to help in meeting the requirements of welfare reform. Under the Job Training Partnership Act, 640 similar councils in place across the country engage over 10,000 private sector volunteers in overseeing the training and placement into jobs of welfare recipients, other low income adults and youth, as well as dislocated workers. We anticipate that States and communities will actively engage these councils in meeting the Jobs Challenge.

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Conclusion

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