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# BOOMERS AND THE BUDGET: WHAT DOES IT MEAN FOR AMERICA'S SENIORS?

## HEARING

BEFORE THE

## SPECIAL COMMITTEE ON AGING
## UNITED STATES SENATE

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# BOOMERS AND THE BUDGET: WHAT DOES IT MEAN FOR AMERICA'S SENIORS?

**THURSDAY, FEBRUARY 15, 2007**

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.*

The committee met, pursuant to notice, at 10:03 a.m., in room 562, Dirksen Senate Office Building, Hon. Gordon H. Smith (ranking member of the committee) presiding.

Present: Senator Smith.

## OPENING STATEMENT OF SENATOR GORDON H. SMITH, RANKING MEMBER

Senator SMITH. Good morning, ladies and gentlemen. We welcome you to this hearing of the Senate Special Committee on Aging.

Senator Kohl is the chairman of this Committee, and he and I continue to have, as we did in the 109th Congress, a very constructive and bipartisan relationship that continues the tradition of this Committee.

Senator Kohl is delayed because of his need to be in an Appropriations Committee markup and will be here when, and if, he is able to make it.

In addition, we have two scheduled votes, I believe, at 10:30. So I would propose that, after my statement, we get everybody's testimony in. Then we can recess for a brief time and come back for Q&A.

With each new year comes a new budget and a new responsibility for Congress to ensure that our Government and the important programs it supports are sufficiently funded.

Last week, President Bush released his outline for fiscal year 2008. I felt it appropriate to convene members of this Committee to hear directly from top agency officials on how programs and services for seniors will be impacted by the President's budget.

Today, we are fortunate to be joined by Commissioner Michael Astrue of the Social Security Administration; Acting Administrator Leslie Norwalk of the Centers for Medicare and Medicaid Services; Assistant Secretary for Aging Josefina G. Carbonell at the Administration on Aging; and Assistant Secretary Brian Montgomery at the Department of Housing and Urban Development.

All our witnesses' respective agencies are vitally important to this discussion, and I look forward to their comments.

I would like to extend a special thank you to Commissioner Astrue, whose first day on the job was this past Monday. He re-

minded me he is entitled to a honeymoon of at least a week. [Laughter.]

I appreciate his willingness to make this debut before Congress as the new SSA commissioner here before the Aging Committee.

In my opinion, the Social Security Administration is one of the Government's most important agencies to the well-being of society's most vulnerable. I look forward to speaking with Commissioner Astrue about SSA's funding needs to ensure that the agency continues to provide quality service.

Along with SSA, the Centers for Medicare and Medicaid Services is tasked with running some of the most vital programs for our health-care safety net. I am deeply concerned about the impact of many of the proposals put forth in the fiscal year 2008 budget related to Medicare and Medicaid. Given that about 92 million Americans receive benefits from these important programs, we should think twice before cutting care to those in need solely on the basis of reducing costs.

I am pleased with the President's request to provide funding for the newly created Choices program at the Administration on Aging (AoA). America's baby-boomer population is facing the often tough process of planning for their long-term care needs, and the Choices program will help them make more informed decisions.

This is definitely a step in the right direction, but we need to recognize that the budget for the agency as a whole has been cut by $28 million from 2007. As AOA is a main source of funds for the coordination of local services for the elderly across America, I look forward to hearing from the assistant secretary on this and other critical resources at AOA.

Last, we are fortunate to have with us today Assistant Secretary Montgomery from the Department of Housing and Urban Development. HUD provides critical housing programs and services for the elderly, such as a reverse mortgage program and assistance programs for those who need affordable housing. My hope is that the assistant secretary will shed some light on the funding needs of these important programs.

So, with that, awaiting our Chairman, I think in the interest of time we will go ahead.

So, Michael, take it away.

## STATEMENT OF MICHAEL ASTRUE, COMMISSIONER, U.S. SOCIAL SECURITY ADMINISTRATION, WASHINGTON, DC

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

Mr. Chairman and members of the Committee, I am very pleased to be here today to discuss the impact of past years' budget allocations on Social Security beneficiaries now and in the future.

Let me say at the outset that we appreciate your unflagging support for SSA, and I am looking forward to working with you and this Committee during my term.

As I said at my confirmation hearing, my goal is to be a good steward of the program for both current and future beneficiaries. For current beneficiaries, this role means setting high standards for management, performance, service and program integrity, and committing to meeting those standards. It also means being pains-

taking in making sure the Agency adheres to the law and best-demonstrated practices of accounting, efficiency and compassion.

For future beneficiaries, good stewardship means engaging with others in the Agency and the executive branch, with members of this Committee and other Senators, as well as outside groups and experts, to provide unbiased data about all the options for safeguarding the financial stability of the program.

It is part of our obligation to the American public that we must continue the best possible support for older Americans, people with disabilities and their families in the coming decades.

SSA's mission is to deliver high-quality service to every claimant, beneficiary and the American taxpayer. In my written statement, I detail the magnitude of those workloads.

Our traditional workloads are to make Social Security and SSI payments, process benefit claims and conduct hearings on appeals of SSA decisions. We also issue new and replacement social security cards, process earnings records, issue Social Security statements, and handle transactions through the 800-number service centers.

At the same time, other workloads are growing, not only due to demographics, but also because many pieces of new legislation require SSA to undertake additional work.

For example, the new Medicare prescription drug program required that, among other responsibilities, SSA take applications and make eligibility determinations for individuals with limited income and resources who might qualify for extra help with prescription drug coverage.

In the last 5 years, reductions to the President's budget requests have totaled $720 million, equivalent to about 8,000 workyears. These numbers are not just statistics. They represent a diminished level of service. I share your concern about the impact this reduction has had on applicants who filed for disability benefits.

The Commissioner of Social Security has very little discretion relating to most of the Agency's expenditures. Almost everything the Agency does is mandated by Congress. So, unlike a regulatory agency that can prioritize enforcement or a grant-making agency that can impose a percentage cut across the board, the Commissioner does not have that flexibility.

For example, in recent years, SSA has concentrated resources on handling initial claims. However, the number of hearings pending, as well as processing times at the hearings level, has continued to increase since fiscal year 2001. The outlook for fiscal year 2007 is even more challenging.

Unfortunately, funding for SSA's administrative expenses will be $200 million below the President's budget request. For a time, it appeared that the shortfall would be much greater.

We appreciate the significant increase from fiscal year 2006 levels that was included in House Joint Resolution 20, as it was approved yesterday, I believe, by the Congress.

We also are greatly relieved that we will not have to resort to employee furloughs, which looked like a real possibility.

However, reductions from the President's budget for the coming year would have a direct effect on SSA's ability to process key workloads. If we had received the President's budget each year

from fiscal year 2002 through fiscal year 2006, SSA would be in much better shape, not only in initial disability claims and hearings backlogs, but also in program integrity work.

Funding shortfalls have meant substantial reductions in scheduled program integrity activities, which include reviewing whether recipients of disability insurance benefits continue to be eligible and whether SSI recipients continue to meet income and resource criteria for program eligibility.

We have faced some increasingly difficult decisions. Over time, as we worked to keep pace with initial claims and hearings, we reduced spending for program integrity work, and that is a very disturbing trend. This work is tremendously important for safeguarding the trust funds, as well as the Treasury's general revenue funds. Social Security continuing disability reviews save $10 for every $1 invested, and SSI redeterminations save $7 for every $1 spent.

Accordingly, the President's budget for fiscal year 2008 includes $213 million for increased program integrity work and proposes a comparable adjustment to the discretionary spending caps. My written statement details the number of CDRs and redeterminations that we estimate this funding will allow.

In conclusion, Mr. Chairman, let me express my gratitude to my predecessor, Commissioner Barnhart, for her excellent work throughout her tenure. I will do everything I can to live up to her standard and will be another good steward for the Social Security Administration.

I know that our employees have a deep commitment to finding better ways to be more responsive to those who depend on our service and fiscal stewardship.

Thank you. I will be happy to answer later any questions that you or other members of the Committee may have.

[The prepared statement of Mr. Astrue follows:]

# FY 2008 Budget Impact on Baby Boomers

**Statement of**

**Michael J. Astrue**
**Commissioner**
**of**
**Social Security**

**Before the**

**Senate Special Aging Committee**

**February 15, 2007**

**Statement of Michael J. Astrue**
**Commissioner of Social Security**
**Before the Senate Special Aging Committee**
**February 15, 2007**

**Mr. Chairman and Members of the Committee:**

I am pleased to be here today to discuss the impact of past years' budget allocations on Social Security beneficiaries, and the upcoming retirement of the baby boom generation. I want to thank you for holding this hearing and giving us the opportunity to tell you of our accomplishments and our challenges in this era of constrained resources and growth in Social Security Administration's (SSA) workloads. This is my first appearance before the Committee, and I appreciate your unflagging support for SSA and the programs entrusted to our Agency. The members of this Committee know well the importance of these programs to virtually every American family.

I am honored to serve as Commissioner of Social Security. SSA has a proud history of excellent service to the public, and I promise to do everything in my power to continue that tradition. I also am looking forward to working with this Committee during my term.

As I said at my confirmation hearing, my goal is to be a good steward of the program for both current and future beneficiaries. For current beneficiaries, this role means setting high standards for management, performance, public service, and program integrity, and committing to meeting those standards. It also means being scrupulous and painstaking in making sure the Agency adheres to the law and employs best-demonstrated practices of accounting, efficiency, and compassion.

For future beneficiaries, good stewardship means engaging with others in the Agency and the Executive branch, with members of the Committee and other members of Congress and outside groups and experts to provide unbiased data about all the options for safeguarding the financial stability of the program. It is part of our

obligation to the American public that we must strive to continue the best possible support for older Americans and people with disabilities and their families in the coming decades.

**Core Workloads**

SSA's priority is to deliver high-quality, citizen-centered service to every claimant, beneficiary, and the American taxpayer. In FY 2006, SSA maintained individual payment records for more than 53 million people who received Social Security benefits or Supplemental Security Income (SSI) each month. During this time those payments exceeded $586 billion. Social Security employees processed nearly 3.8 million Retirement and Survivors Insurance benefits claims; 2.5 million disability claims; over 2.5 million SSI claims, and conducted 559,000 hearings. To conduct these and other workloads, SSA served approximately 42 million visitors to its nearly 1,300 field offices in communities across America.

These are SSA's core workloads, but we do much more than pay cash benefits. Among other things, in FY 2006, SSA issued over 17 million original and replacement Social Security cards; processed 265 million earnings items to maintain workers' lifelong earnings records; handled nearly 60 million transactions through SSA's 800-number; issued over 145 million Social Security Statements; and participated in over 84 million SSN verifications for employers.

In addition, other workloads are also growing because of new legislation requiring SSA to undertake additional work. The Social Security Protection Act of 2004, the Intelligence Reform and Terrorism Prevention Act of 2004, the Deficit Reduction Act of 2005, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA, have all added new and non-traditional workloads.

For example, the MMA, enacted in December 2003, established the new Medicare prescription drug benefit. The new Medicare prescription drug coverage was designed to allow all people with Medicare an opportunity to voluntarily enroll in prescription drug coverage. MMA also provided for an additional level of assistance, "extra help," for people with Medicare prescription drug coverage who

have limited incomes and resources. SSA, along with State Medicaid programs, was given the responsibility to take applications and to make eligibility determinations for this "extra help."

In addition, Congress is considering several immigration related bills that could have a significant impact on SSA workloads. For example, there are several bills that would require employers to verify the employment eligibility of all new hires. Depending on the details of these proposals, the impact on SSA workloads could be significant.

Since 2001, SSA has improved productivity on average by 2.5 percent per year for a cumulative improvement of 13.1 percent. These increases have been possible through the efforts of an outstanding workforce aided by technology, and despite appropriations that each year were significantly below that proposed in the President's budget. Since the President's budget requests for SSA have assumed the Agency would achieve a two percent productivity gain each year, even these impressive gains cannot compensate for the funding reductions the Agency has faced over this period.

We are moving forward with additional electronic enhancements. We offer safe and convenient online systems for individuals to file claims, submit changes of address or direct deposit information, request replacement Medicare cards, and verify benefits. In FY 2006, 335,000 people applied for benefits online, up 27 percent from the previous fiscal year. In addition, 75 percent of 265 million wage reports in FY 2006 were filed electronically online, compared to only 27 percent in FY 2001. We are also continuing to implement the electronic disability system, known as eDib, to move from a paper to an electronic case process. We believe this will significantly reduce processing times and improve the quality of the disability determination process.

Despite budget constraints, SSA has still been able to handle more work in a shorter period of time. We have seen a reduction in processing time for initial disability claims, from 106 days in FY 2001 to 88 days in FY 2006. We have seen a significant reduction in processing time for appeals of hearing decisions, from 447 days in FY 2001 to 203 days in FY 2006, and in FY 2006 we processed over

365,000 more initial disability claims, conducted approximately 163,000 additional SSA hearings, and nearly 700,000 more retirement and survivors claims than in FY 2001.

We are also taking steps to improve the overall disability claims process. As a result of a review conducted under former Commissioner Barnhart, we developed a disability approach that focuses on making the right decision as early in the process as possible. The new initiative will be gradually implemented so that we can carefully monitor the effects of the changes on the entire disability process.

These achievements are especially noteworthy in light of the fact that our administrative expenses are less than two percent of total outlays administered by SSA.

**Agency Efforts to Balance Workloads and Resources**

Despite this record, we are keenly aware of how much more we could have accomplished had we received the President's budget requests in past years. In the last five years, reductions to the President's budget request have totaled $720 million, equivalent to approximately 8,000 workyears. These numbers are not just statistics, and I share your concern about the impact this has on applicants who file for disability benefits. These numbers represent real effects on the service that people receive from our Agency, and place increasing pressure on our ability to maintain our physical and electronic infrastructure.

And the outlook for FY 2007 is even more challenging. It appears that funding for SSA's administrative expenses in FY 2007 will be $200 million below the President's budget request. For a time, it appeared that the shortfall would be much greater and we appreciate the significant increase from FY 2006 levels that was included in H.J. Res. 20 as it was approved by the House. And we are greatly relieved that we will not have to resort to employee furloughs.

But I must tell you that we expect the level of service we are able to provide the American people to diminish during FY 2007. It is no secret that our backlogs are growing. As of December 2006, we

have nearly 718,000 hearings pending, over 568,000 initial disability claims pending, as well as millions of post-entitlement actions to be processed. The number of initial disability claims and hearing requests received has remained above FY 2001 levels.
Since FY 2002, Congress has reduced SSA's budget from that requested by the President, and our funding needs have not been met. As a result, we have had to concentrate our resources on handling initial claims. Consequently, the number of hearings pending as well as processing times at the hearings level has continued to increase since FY 2001.

Even if we had received the President's budget request for FY 2007, we would still have to deal with staffing shortages. With funding at the requested level, we would have been able to fill only one out of three vacancies in our offices. With the expected funding level, we likely will have limited hiring flexibility during the remainder of the year to replace the estimated 4,000 SSA and Disability Determination Service employees who will be retiring or resigning. Since vacancies rarely are distributed evenly across offices, some places will be harder hit than others. And the overtime hours that we traditionally rely on to accomplish a number of important workloads will be cut by at least half.

**FY 2008 and Program Integrity**

And so we face some increasingly difficult decisions. Over time, as we worked to keep pace with initial claims and hearings, we reduced spending for program integrity work, such as continuing disability reviews, or CDRs, which determine whether an individual may still be considered disabled, and SSI redeterminations, which review non-disability eligibility criteria. SSA's actuaries estimate that CDRs save $10 in program benefits for every dollar spent in conducting the review; SSI redeterminations an estimated $7 in savings.

Accordingly, the President's budget for FY 2008 includes $213 million for increased program integrity work and proposes a comparable adjustment to the discretionary spending caps. This would enable SSA to increase the number of full medical CDRs from 198,000 in

FY 2007 to 398,000 in FY 2008, and the number of SSI non-medical eligibility redeterminations from 1,026,000 in FY 2007 to 1,526,000 in FY 2008.

SSA's progress towards accomplishing its mission is directly linked to the level of resources it receives. If we had received the President's budget each year from FY 2002 through FY 2006, SSA would have been able to reduce the backlogs for initial disability claims and hearings. Funding at the President's budget level would also have allowed the Agency to fund program integrity activities at a more appropriate level. These activities permit SSA to ensure that recipients of disability insurance benefits continue to be eligible and that SSI recipients continue to meet income and resource criteria for program eligibility.

**Conclusion**

Finally, Mr. Chairman, I assure you that SSA will do the best it can to provide the American people with the service they need, and I know firsthand how important the program can be to a family facing catastrophic illness or the loss of a family member. It is clear that we are stretching our ability to balance funding realities with the quality service the American people have come to expect from our Agency, but I know that our employees have a deep commitment to finding better ways to be more responsive to those who depend on our service and fiscal stewardship.

Thank you, and I will be happy to answer any questions you may have.

Senator SMITH. I have just been informed that there will be three votes. So what I am going to try to do is ask each of you a question and try and get this hearing done. This deserves a lot more time than we are being given, but three votes will take 45 minutes to an hour, and I know you all have schedules, as well.

So such questions that are not asked by me or colleagues who may yet show up, will be submitted to you in writing for your responses.

How about backlogs? You got a handle on those, Michael?

Mr. ASTRUE. Well, I am working on it. It really is an important priority for me and one of my main interests in coming back to the Agency.

It is going to take a little bit more time to decide what we are actually going to do.

One thing that I have said is there has been an important initiative in the Agency, that is being tested in the Boston region, on a number of changes to the disability system. I think the intent of the plan was to treat that as a package and then roll it out region by region, one or two a year for many years.

I think that we have to approach the backlog issue with much more urgency than that, so what I have indicated is——

Senator SMITH. Do you have the resources?

Mr. ASTRUE. Well——

Senator SMITH. I mean, I am specifically concerned about disability cases and the transition from paper to electronics.

Mr. ASTRUE. The resources are a real issue. Let me focus, perhaps, just on one for a moment, which is at the Office of Disability Adjudication and Review (ODAR), which handles all of the hearings and appeals.

The Administrative Law Judges (ALJs)—our numbers stayed flat, approximately, over the last 5 years for the case levels. The threat of furloughs has meant that we have had a hiring freeze. There are severe restrictions on overtime.

The impact specifically, if I remember the numbers correctly on ODAR, is that for support staff for each ALJ—because we try to highly leverage the ALJs—5 years ago, it was about 5.2 employees per ALJ; that is down to about 4.2. That has, I think, had a serious impact on the efficiency of the ALJ work.

Plus, we have the issue—we have been waiting for some time, and I gather that help is maybe imminent—but we haven't been able to get a new roster for ALJs for 10 years. However, if that roster comes out later this year, depending on where the funding is, it is going to be difficult to hire the number of ALJs that we would need to make a serious dent in that (ODAR) workload. So that is, I think, very dependent on the funding.

At the earlier stage of the process, the funding is important too. We may have a little bit more flexibility, through administrative changes, to make some impact on those workloads. But clearly, if the funding stays bare-bones, it could be very limited in terms of what we do, particularly since a lot of the changes that are going to be efficient over the long run require technology investments up front.

If you are dealing with furloughs and restrictions on workloads, you are clearly dealing with budgets where you are just making

patches in the systems, instead of the larger investments that are more efficient in the long run.

Senator SMITH. I am going to have one other question for you, Michael, but it is really a joint question for you and Leslie.

So, Leslie, why don't we go to your testimony?

**STATEMENT OF LESLIE NORWALK, ACTING ADMINISTRATOR, CENTERS FOR MEDICAID AND MEDICARE SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Ms. NORWALK. Senator Smith, I would like to thank you and Chairman Kohl for inviting me this morning to discuss the President's fiscal year 2008 budget proposals. I am honored to share this panel with my very distinguished colleagues.

As you know, CMS is the largest purchaser of health care in the world. We will provide coverage under Medicare, Medicaid and SCHIP to nearly 100 million beneficiaries in fiscal year 2008. That is roughly one in three Americans.

Combined, Medicare and Medicaid pay about one-third of National health expenditures and account for nearly one-fifth of the President's overall budget.

This Administration has worked for the past 6 years to efficiently and effectively manage Medicare, Medicaid and all programs that impact seniors. Together with Congress and our partners, especially those joining me at the table today, we have made great strides in improving health-care benefits and quality for millions of seniors.

The new Medicare prescription drug benefit, or Part D, is a great example of our collaborative efforts and one that has had a profound impact on seniors' lives. Just one year into the new benefit, more than 90 percent of people with Medicare have drug coverage, and that is from Medicare Part D or another source. Beneficiary satisfaction is high, and the costs that were projected initially are lower, both for beneficiaries and for taxpayers.

Unprecedented collaboration at the Federal, State and local levels made this initial success possible, and it continues today. We continue to work with our partners, including the Administration on Aging, to reach additional seniors who could benefit from Part D, particularly those who might qualify for the low-income subsidy.

We have been working diligently to address systems and other issues that have arisen, and I am particularly grateful to SSA in this regard for its collaboration.

I recognize many on this Committee are aware of problems encountered with the premium withhold, and I want to assure you that we are working closely with SSA to address those problems.

Medicare Advantage has also been a great success for the Medicare program, providing valuable assistance to millions of seniors. On average in 2006, beneficiaries enrolled in Medicare Advantage plans saved about $82 a month in out-of-pocket expenses and are expected to save even more in 2007. Beneficiaries in all 50 States now have access to at least one Medicare Advantage plan.

Experts have underscored repeatedly in recent years the importance of taking action now to address Medicare's long-term financial challenges. For example, in its March 2006 report to Congress,

MedPAC cautioned, "Even if policymakers succeed at moving providers toward greater efficiency, they may still need to make other policy changes to help ensure the program's financing is sustainable into the future." The President's budget is a first step toward doing just that. The President's budget for Medicare and Medicaid focuses on long-term sustainability for both programs. We are committed to modern, comprehensive care for those currently enrolled and to ensuring that future generations of seniors have access to comparable benefits.

Legislative and administrative changes proposed for the Medicare program would slow the projected annual average growth over the next 5 years from 6.5 percent to 5.6 percent per year. Our Medicaid proposals would slow the growth rate from 7.3 percent to 7.1 percent over that same time period.

In addition to the budget's reform initiatives, we have implemented many provisions of the Deficit Reduction Act signed into law last year.

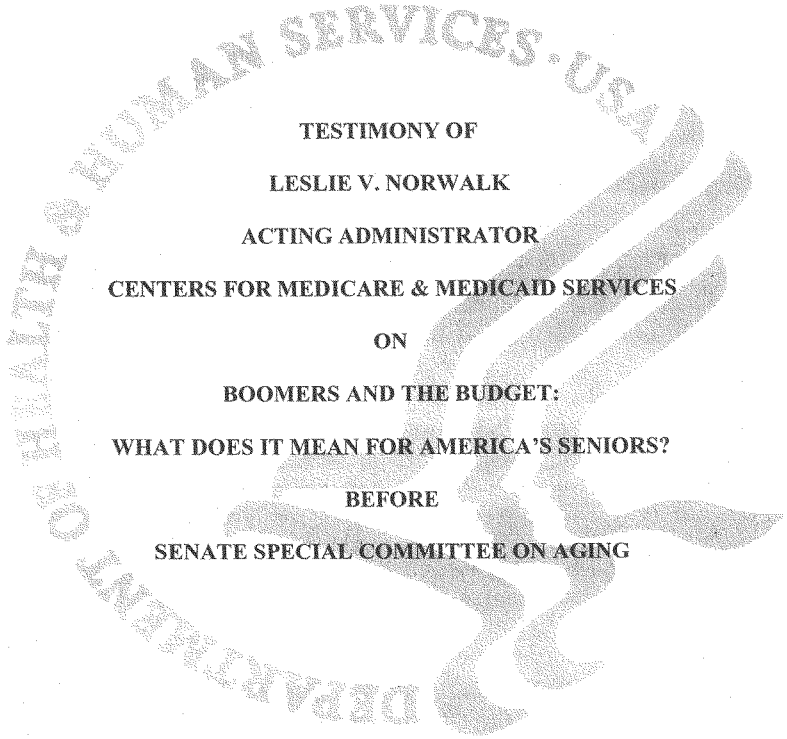
These reforms represent the most important changes in 15 years to end the long-standing Medicaid bias toward institutional care. While institutional care may be the best choice for many, provisions in the DRA, like cash and counseling and Money-Follows-the-Person, are helping to make home and community-based services a real option for Medicaid beneficiaries, particularly those who are dual-eligible.

Finally, I want to acknowledge the letter that three members of this Committee and seven other Senators sent to the President on Tuesday offering to work together to pass legislation that would: ensure that all Americans have affordable, quality, private health-care coverage, while protecting Government programs; modernize Federal tax rules for health coverage; create more opportunities and incentives for States to design solutions for their citizens; take steps to create a culture of wellness through prevention strategies, rather than perpetuating our current emphasis on sick care; encourage more cost-effective, chronic and compassionate end-of-life care; and improve access on information on price and quality of services.

CMS is committed, with Congress, to continue improvements to Medicare, Medicaid, SCHIP reauthorization and initiatives like affordable choices that ensure all Americans have access to affordable, quality, private health insurance. Through innovation and modernization, we can make all of these programs stronger for today's seniors and future generations.

I thank you, Senator. I am happy to take whatever questions you have now and certainly answer those that you want to submit for the record.

[The prepared statement of Ms. Norwalk follows:]




**TESTIMONY OF**

**LESLIE V. NORWALK**

**ACTING ADMINISTRATOR**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**ON**

**BOOMERS AND THE BUDGET:**

**WHAT DOES IT MEAN FOR AMERICA'S SENIORS?**

**BEFORE**

**SENATE SPECIAL COMMITTEE ON AGING**

**February 15, 2007**

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

**Testimony of Leslie V. Norwalk**
**Acting Administrator, Centers for Medicare & Medicaid Services**
**on**
**"Boomers and the Budget: What Does it Mean for America's Seniors?"**
**Before the**
**Senate Special Committee on Aging**
**February 15 2007**

Good afternoon Chairman Kohl, Senator Smith, and distinguished members of the Committee. I am pleased to be here today to discuss proposals in the President's fiscal year (FY) 2008 Budget for programs administered by the Centers for Medicare & Medicaid Services (CMS) that impact seniors: Medicare and Medicaid. I would also like to highlight some of CMS' ongoing initiatives that improve seniors' lives, such as personalized assistance with new Medicare benefits, and a commitment to quality and transparency that empowers beneficiaries.

**Ongoing Initiatives to Strengthen Medicare**

For the past six years, this Administration has worked to manage Medicare and Medicaid efficiently and effectively. Together with Congress, we have made great strides in modernizing and improving health care benefits for seniors, with millions now living healthier, fuller lives. Perhaps the best example of such improvements is the Medicare prescription drug benefit (Part D) enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Available to beneficiaries for the first time in January 2006, the program has been a resounding success. At last count, more than 90 percent of people with Medicare now have coverage for prescription drugs from Part D or another source, including almost 10 million low-income beneficiaries receiving comprehensive coverage with low or zero premiums and nominal cost-sharing. Beneficiary satisfaction with Part D is consistently at 75 percent or more, reaching above 90 percent for low-income beneficiaries receiving extra help.[1]

[1] KRC Research survey for the Medicare Rx Education Network, conducted September 1-7, 2006.

Strong enrollment and beneficiary satisfaction are just two elements of the Part D success story, however. Equally important, Part D premiums and estimated program costs have been declining steadily thanks in part to competition among plans, smart choices by beneficiaries, and lower-than-expected growth in prescription drug spending. Since last year's mid-session review, projected payments to Part D plans for the ten-year period 2007-2016 have dropped by $113 billion, of which $96 billion is directly attributable to competition and lower plan bids. The average beneficiary premium for basic benefits is now estimated to be around $22 per month, down from $23 in 2006 and 42 percent lower than the original projection.

We also are seeing exciting trends in the Medicare Advantage program. Through Medicare Advantage, beneficiaries have access to integrated health and prescription drug benefits, often with lower premiums and cost-sharing than under fee-for-service Medicare. Medicare Advantage is a particularly important program for lower-income Medicare beneficiaries, who might otherwise struggle with Medicare's cost-sharing or with supplemental insurance premiums that can be costly. Fifty-seven percent of beneficiaries enrolled in Medicare Advantage report income between $10,000 and $30,000 compared to 46 percent of fee-for-service beneficiaries.[2] Racial and ethnic minorities also benefit from the Medicare Advantage program; minorities represent 27 percent of total Medicare Advantage enrollment, compared with 20 percent in fee-for-service.[3] Enrollment in Medicare health plans has now reached an all-time high of 8.3 million beneficiaries, up from 5.3 million in 2003. In 2007, beneficiaries in all fifty states have access to Medicare Advantage plans – a significant improvement over the pre-MMA days.

**FY 2008 Budget Proposals**

CMS is the largest purchaser of health care in the world. Our programs provide health care coverage to about 92 million beneficiaries, almost one in three Americans. Combined, Medicare and Medicaid pay about one-third of the Nation's health

[2] CMS analyzed the 2005 Medicare Current Beneficiary Survey (MCBS) to determine low-income and minority enrollment in Medicare health plans and in fee-for-service.
[3] CMS analysis of 2005 MCBS data.

expenditures. In FY 2008, Medicare benefit costs and the Federal share of Medicaid and SCHIP benefits are expected to total almost $657 billion. Working closely with beneficiaries and providers, we believe we can improve the quality, efficiency and ultimate viability of the Medicare program.

*Medicare Proposals*

In the past year alone, experts ranging from the Medicare Payment Advisory Commission (MedPAC), to the Medicare Trustees, to Federal Reserve Chairman Ben Bernanke, all have underscored the importance of taking action ***now*** to address Medicare's long-term financial challenges. Testifying before the Senate Budget Committee on January 18, 2007, Chairman Bernanke stated "if early and meaningful action is not taken, the U.S. economy could be seriously weakened, with future generations bearing much of the cost." Similarly, after discussing "serious concerns" with Medicare's financial outlook, the Medicare Trustees cautioned in 2006: "We believe that prompt, effective, and decisive action is necessary to address both the exhaustion of the HI [Hospital Insurance] trust fund and anticipated rapid growth in [Medicare] expenditures."[4] Finally, in its March 2006 Report to Congress on Medicare Payment Policy, MedPAC suggested a number of strategies to address Medicare's long-term sustainability: constraining payment rates for health care providers, rationalizing benefits, increasing the program's financing, and encouraging greater efficiency from health care providers. Concluding that increasing efficiency is most desirable, MedPAC cautioned: "[e]ven if policymakers succeed at moving providers toward greater efficiency, they may still need to make other policy changes to help ensure that the program's financing is sustainable into the future."[5]

Recognizing the gravity of these warnings, the President's Budget strives to induce providers toward greater efficiency with payment policies that increase the role of competition and create a strong financial incentive for providers to slow cost growth through greater productivity and other improvements in efficiency. In addition to

[4] 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds at pp. 3-4.
[5] Report to the Congress: Medicare Payment Policy at pp. xv; 6-8 (March 2006).

encouraging appropriate, high-quality care for people with Medicare, the proposals would reduce the growth in premiums for most beneficiaries. Under current law, and based on the Budget economic assumptions, the assets of the HI trust fund would start to decline in 2015; the Budget proposals would reverse that decline and increase the value of the HI Trust Fund throughout the ten-year window.

When combined with Medicare administrative proposals,[6] the FY 2008 Medicare legislative proposals including those described below would save $5.3 billion in FY 2008 and $75.9 billion over five years.[7] The net effect is a reduction of less than one percentage point in the rate of growth for Medicare over the five-year budget window. Medicare's current average annual growth rate over the next five years is projected at 6.5 percent per year. Under the President's Budget, that rate of growth would slow to 5.6 percent per year. Specifically, the Budget would:

- Foster Productivity and Efficiency: Responds to inefficient health care delivery and rapid spending growth with provider payment adjustments that would account for expected productivity gains and induce providers to achieve efficiencies that restrain costs;

- Rationalize Medicare Payment and Subsidies: Ties payment to reporting of medical errors and expands value-based purchasing for hospitals; encourages appropriate payment for five common post-acute care conditions; addresses excessive Medicare payment and beneficiary coinsurance for power wheelchairs and oxygen equipment;

- Improve Program Integrity: Facilitates proper coordination of benefits through improved data sharing; creates incentives for providers to recoup their debts;

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[6] The Medicare budget assumes administrative savings of $1.0 billion in FY 2008 and $10.2 billion over five years. Savings will result from new efforts to strengthen program integrity in Medicare payment systems, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity.

[7] The savings estimates are net of a proposal in which Medicare funds are transferred to Medicaid to pay premiums for certain low-income individuals.

strengthens the integrity of the administrative appeals process by limiting Mandamus jurisdiction as a basis for obtaining judicial review;

- Increase High-Income Beneficiary Responsibility for Health Care: Eliminates annual indexing of income thresholds for reduced Part B premium subsidies, and extends the income-related Part B premium adjustment to Part D premiums; and

- Improve Long-Term Sustainability: As a fall-back response if there is no Congressional action, applies a -0.4 percent sequester to the Medicare payment amount for all providers in the first year that general revenue funding for the Medicare program exceeds 45 percent. The sequester reduction would grow by an additional 0.4 percent in each successive year that the general revenue funding remained above 45 percent.

*Medicaid Proposals*

Many of the most vulnerable seniors also rely on Medicaid for help with Medicare premiums and other cost-sharing, and additional benefits. In 2006, 4.9 million Medicaid enrollees were aged 65 and over; an additional 8.3 million were blind and disabled. Collectively, these groups accounted for more than 25 percent of total Medicaid enrollment in 2006.

In FY 2008, we are proposing a series of legislative changes that will result in gross savings of $12 billion over the next five years, which will keep Medicaid up-to-date and sustainable for years to come. The Budget also announces plans for several administrative initiatives that achieve an additional savings of approximately $13 billion over five years. The President's FY 2008 Medicaid reform proposals would slow the average annual growth rate in Medicaid over the next five years from 7.3 percent per year to 7.1 percent per year.

Specifically, the Budget includes the following proposals:

- Long-term Care: Ensures that Medicaid long-term care services are protected for those who need it most by removing the state option to define substantial home equity between $500,000 and $750,000;

- Program Integrity: Improves Medicaid management that will help states avoid paying unnecessary costs through improved third-party liability reforms and more effective Medicaid eligibility processes;

- Pay-for-Performance: Requires states to report on performance measures and link their performance to federal Medicaid grants; and

- Pharmacy Reforms: Builds on reforms in the Deficit Reduction Act of 2005 (DRA) to further rationalize Medicaid payments for prescription drugs and to give states more private sector tools to manage drug spending;

- Reimbursement Reform: Aligns Federal reimbursement for administrative services and targeted case management to create consistency in matching rates across these activities.

In addition to these proposed initiatives, the Administration has implemented many of the reforms included in the Deficit Reduction Act (DRA) which was signed last year by the President. Provisions of the DRA represent the most important reforms in 15 years to end the longstanding Medicaid bias toward institutional care. Institutional care may still be the best choice for many, but the DRA helped make home- and community-based care a real option for Medicaid beneficiaries. The law created strong financial incentives and opportunities for States through options like Money Follows the Person and Cash and Counseling, which give disabled Medicaid beneficiaries, their caregivers, and families the ability to choose the optimal setting for long-term care needs.

*Access Proposals*

In addition to taking steps towards securing the future of Medicare and Medicaid, the President's Budget demonstrates commitment to preserving and expanding health insurance coverage for all Americans. When it comes to health care, the tax code is biased in favor of individuals who receive insurance from their employers. To remove this inequality, the President proposes replacing the existing – and unlimited – exclusion for employer-sponsored insurance with a flat standard deduction for health insurance (SDHI) for those with at least catastrophic health insurance. As long as a family has at least a catastrophic health insurance policy, they will be able to deduct the first $15,000 from their income ($7,500 for an individual), regardless of whether they receive their health insurance policy from their employer or purchase it in the non-group market. This will foster a true marketplace for health care, encourage competition, improve the efficiency of the system, and reduce the ranks of the uninsured.

The Federal Government's current system of paying for health care results in billions of dollars being spent inefficiently through a patchwork of subsidies and payments to providers. In addition to directly funding the care provided to people enrolled in programs like Medicare and Medicaid, health care entitlement programs finance payments to institutions that either indirectly pay for uncompensated care or subsidize their operating expenses.

The health care system could operate more efficiently if some portion of institutional payments instead were redirected to help people with poor health or limited income afford health insurance. The uninsured often use emergency rooms as a source of primary care, which leads to suboptimal care and spending outcomes. If this public spending were focused on helping the uninsured purchase private insurance, people would receive the care they need in the most appropriate setting. The health care system needs to be transformed in a way that avoids costly and unnecessary medical visits and emphasizes upfront, affordable private health insurance options.

This transformation could happen by subsidizing the purchase of private insurance for low-income individuals. However, any such health care reforms would need to be State-based and budget neutral within health care spending, not create a new entitlement and not affect savings contained in the President's Budget that are necessary to address the unsustainable growth of Federal entitlement programs. The Federal Government would also maintain its commitment to the neediest and most vulnerable populations, while acknowledging that States are best situated to craft innovative solutions to move people into affordable insurance. The Secretary of HHS will be working with Congress and the States in the upcoming year to achieve health care marketplace reforms, called "Affordable Choices."

The Administration also is committed to working with Congress to reauthorize the SCHIP program this year. SCHIP has provided $40 billion over the last ten years to states to provide health care coverage to low-income, uninsured children who are not eligible for Medicaid. Specifically, the Budget proposes to:

- Reauthorize SCHIP for five years;
- Increase funding by approximately $5 billion ($4.8) over the next five years;
- Redirect approximately $4 billion in unexpended funds – taken together with the increase in funding, nearly $9 billion will be made available for the program, enough to meet projected demand for targeted enrollment in fiscal year 2008; and
- Refocus the program on low-income, uninsured children and pregnant women in families with incomes at or below 200 percent of the federal poverty level, as Congress originally intended.

**A New Paradigm: Personalized Assistance Supports Health Care Decision-Making**

Along with the commitment to promoting long-term Medicare and Medicaid sustainability, it is a top CMS priority to change the way seniors make health care decisions. The unprecedented partnerships and outreach efforts that began in anticipation of the first Part D open enrollment period continue today and will be a permanent part of the Medicare program moving forward. CMS is working today with a strong network of

partners, including the Administration on Aging (AoA), the U.S. Department of Housing and Urban Development (HUD), and the Social Security Administration (SSA) to reach beneficiaries "where they live, work, play, and pray" as part of our transformation from health care bill payer to a public health agency.

In 2005, CMS built a network of thousands of partners, and hosted tens of thousands of events across the country. When the initial Part D enrollment period ended on May 15, 2006, more than 90 percent of people with Medicare had coverage for prescription drugs through Part D or another plan. CMS continued these outreach efforts throughout 2006, with the goal of educating every senior that they again had a choice to make about prescription drug coverage. "Prepare and Compare" was our mantra and people with Medicare did just that.

A CMS tracking survey indicated an extremely high level of awareness in Fall 2006, with more than half of our respondents having reviewed their current coverage -- specifically comparing premiums, deductibles or co-pays, and coverage levels. Medicare beneficiaries and those who care for them showed once again that they are informed consumers. More than 87 percent of all beneficiaries who enrolled in a prescription drug plan for 2007 have chosen a plan with coverage other than the standard benefit, such as no deductible, fixed co-pays, or coverage in the gap. Seniors seem to be thriving on choice in the Medicare program, and CMS is committed to providing the tools that are needed for beneficiaries to understand and evaluate their options.

Medicare also is working to change the health care decision-making paradigm for its beneficiaries, giving them new tools and creating a new environment that will allow them to make more informed choices about their health and take more action on their own to stay healthy. The community-based outreach that was part of the Part D enrollment process, the far-reaching partnerships, and unprecedented, personalized support for beneficiaries and caregivers will be permanent features of the Medicare program.

As an example, the *My Health. My Medicare* initiative is designed to help everyone with Medicare make the most of their benefits. Providing beneficiaries with personalized information—online, on the phone and in person—helps them understand and access new preventive services they may not yet be familiar with, and online comparison tools provide access to provider quality information and cost/coverage data.

CMS will continue to provide increased support to help seniors through 1-800 MEDICARE. The 1-800 MEDICARE line received 42.2 million calls in FY 2006 – nearly one call for every beneficiary and roughly two-times the FY 2005 volume of 21.8 million calls. High volumes continue in January 2007, 1-800 MEDICARE received 3,046,708 million calls. Available 24-hours a day, 7-days a week, 1-800 MEDICARE is unrivaled in its potential to answer seniors' health care questions anytime, no matter where they are.

Finally, in addition to reaching out to seniors, Medicare is using its sizeable presence in the healthcare marketplace to encourage greater awareness and use of preventive services and to facilitate a more quality-conscious, more transparent, and more collaborative health care environment. By facilitating information exchanges among beneficiaries and providers, CMS can reward smart decision-making with better care *and* lower costs.

**Conclusion**

In addition to proposals in the President's FY 2008 budget, CMS remains committed to a core mission to provide continuous quality improvement across all of our programs. Medicare is becoming a partner in helping seniors and people with disabilities stay healthy and make informed decisions about their health care needs. Medicare and its network of partners is delivering support, information, and personal assistance at the local and individual level – and this support is not going away. We look forward to working with Congress in the year ahead to improve and strengthen our programs, keeping our commitment to America's seniors today and for years to come.

Senator SMITH. Thank you, Leslie.

As you might recall, you and I met with Michael's predecessor, and we discussed the enormous transition difficulties in implementation on Medicare Part D. I expressed to you then, and I express to you now, the frustration that many feel, and I have certainly felt, that beneficiaries are bearing the financial brunt of the Government's inability to correctly withhold Part D premiums from their Social Security checks, and so they come with a one-lump sum recoupment.

During our meeting, I urged that CMS and SSA figure out how to implement a solution that permits beneficiaries the option to have retroactively owed premiums deducted from their checks in installments, rather than the harsh, one-lump sum.

To date, your agencies have not found a solution, and I continue to hear complaints from seniors about this. I am wondering why your agencies can't pull this together, and what you can do to smooth this out.

Ms. NORWALK. Well, we agree that there have certainly been issues in the past over premium withhold, and we find if even one beneficiary has a problem, that is regrettable. We have much work to do to ensure that we can reduce those numbers from one month to the next. We have made some great progress.

As to your specific point about gradually repaying those payments that were not properly withheld to begin with, Mike and I, in fact, had a discussion earlier this week to discuss just that.

Our initial proposal or initial discussions with Social Security in 2005 focused more specifically on paying gradually over time—paying a single month's premium over several months, and we thought that didn't make sense.

Certainly, we did not anticipate the sorts of problems that we have been having with premium withhold, and I think gradually repaying payments that would be overpayments are a different issue.

While Mike and I talked about that from a policy perspective, I think that that makes some sense. It is one of the things that we have been working with the prescription drug plans to allow those beneficiaries who need to repay over a certain amount of time to do that on a gradual basis and appreciate the ease it would be for those beneficiaries to have those taken out of their Social Security checks on a gradual basis rather than a lump sum.

Now, I can't speak specifically to the systems implications it has for Social Security, but I am quite sure that they would not be insignificant.

Senator SMITH. No problem, though, is it, Michael?

Mr. ASTRUE. Well——[Laughter.]

That is partly up to the Congress. I think that certainly whatever decision Acting Administrator Norwalk makes, we will implement as quickly and as effectively as we can.

I do want to acknowledge that, with this era of budget reductions, one of the areas of the agency that has really been taking a hit, and it has been very hard, has been the systems area. The exact amount of time and money that the systems adjustments will require, once we know what any change in policy is, I can't provide

right now, because we don't know what it would be. But we will certainly try to do our best as quickly as possible.

I will say that I certainly have felt, right from the get-go, that CMS has been trying very hard to address this issue. When I was going through the confirmation process, out of respect for the Senate and for Commissioner Barnhart, I walled myself off from the executive branch.

But Mark McClellan, in his last week, and Leslie did ask the White House for me to make an exception, in essence, so they could sit down, particularly while Mark was still on board, to talk through what the experience had been and what we can do better and that type of thing.

So I think there is a genuine commitment to trying to do this better. I had the first level briefing from my staff on this, and so I do know that there has been substantial improvement.

But nobody is fooling him- or herself in thinking that we are where we need to be, because we are not. We are going to continue to try very hard to get to where we need to be.

Senator SMITH. Well, thank you. It is an urgency, and we do need to find a solution. The sooner we do, the better service we are going to provide to seniors on cutting through all the complexity of Part D.

Leslie, anybody on the Finance Committee especially knows the tremendous demographic and financial pressures that Medicare and Medicaid will be under. Yet balanced against the need for sustainability of these programs is just the harsh reality that the President's budget proposes cutting $75.6 billion from Medicare. I don't know how that squares with efficiencies in actually delivering the same care or improved care to seniors.

Where does the $76 billion or $75.6 billion come from?

Ms. NORWALK. Well, it is, of course, that is a 10-year projection. One of the things that we start with for sources of information is MedPAC. Starting with MedPAC, augmented certainly with our Office of the Actuary, as well as work that has been done, watching what we hear from the private market, MedPAC tells us there are a number of questions in determining whether or not current payments are adequate and what changes would be expected to come in the coming year.

They have a number of indicators that they look at across each of the sectors, including beneficiary access, capacity and supply, access to capital, payments and costs, volume, quality, as well as economy-wide productivity and input prices. These are things that help guide not just MedPAC but certainly the agency in determining how to put together its budget.

One of the things that MedPAC said in its executive summary in the report to Congress last March was focusing, in fact, on this efficiency and the productivity gains that they think that providers should be able to make, particularly institutional providers. As I noted in my opening statement, this is particularly important given the sustainability of the program.

One of the comments that MedPAC makes is strategies to address Medicare's long-term sustainability, including constraining payment rates for health-care providers, rationalizing benefits, increasing the program's financing, encouraging greater efficiency

from health-care providers. Increasing efficiency is the most desirable because it would enable Medicare to do more with its resources.

In many of their recommendations in the report from last March, they focus on the productivity across the entire sector. If you look at our budget, productivity, as accounted for by the Bureau of Labor Statistics for this year, I think it is for 2007, is anticipated to be 1.3 percent.

So, you will see many of our recommendations are things like market basket minus half of that number, or .65. So, for example, the hospital sector would be getting an increase in payments of 3.25 percent for fiscal year 2008.

If you look at our proposals over time, you will see that most of them have those sorts of productivity adjustments to the market basket going forward. There are a few exceptions to that, and we also looked at what MedPAC said in most other areas. MedPAC really focuses on a single year. We are looking longer-term.

But we looked at, for example, skilled nursing facilities and home health facilities. MedPAC, looking at those factors I mentioned at the outset, such as access to capital, quality, volume, the ability for beneficiaries to see those particular provider types, recommended for those two facility types just flat rates, no market basket increase at all.

So a lot of our discussion in putting that budget together, we looked very closely at what we are seeing in the markets, the ability for beneficiaries to actually get these services, margins and the like, and we paid very close attention to them across the board.

Senator SMITH. So you are representing the Administration's view that a cut of nearly $76 billion from a current service level basis will not be felt by seniors.

Ms. NORWALK. Well, we do watch from one year to the next. We do want to ensure that seniors continue to have access to these services and they continue to have quality improvements.

In many of the different provider types, we have seen explosive growth in the number of providers that are providing services in any number of these industries. We have not seen them falling off over time. We have seen healthy margins in many of these industries.

Moreover, we are looking at historically what has been happening over time, for example, in the hospital industry. The updates that have been provided historically over the past 20 years are about 63 percent of the market basket. We are proposing an 83 percent of market basket, so it is actually greater than historical reimbursement rates in that particular sector.

So we look at each of those sectors specifically, and absolutely are concerned that seniors have access to these services on an ongoing basis.

Senator SMITH. Well, I could talk to you all day on this, but the vote has started and I do want to get in our other witnesses and their testimony.

So, Josefina Carbonell, thank you for being here. If you can abbreviate it, all of your testimony will be put into the record.

**STATEMENT OF JOSEFINA G. CARBONELL, ASSISTANT SECRETARY FOR AGING, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Ms. CARBONELL. Thank you, Senator Smith, Chairman Kohl, members of the Committee, thank you for this wonderful opportunity to discuss the Administration on Aging's priorities and, our budget request for FY 2008.

We are witnessing sweeping transformations in this country. Every seven seconds today, and for the next 20 years, someone in America will turn 60.

The framers of the Older Americans Act programs anticipated the aging of our population and charted out a vision for a national aging services network of public and private organizations focused on a common mission to ensure the dignity and independence of older Americans.

The Act charged this network with the responsibility to promote the development of a comprehensive and coordinated system of home- and community-based services that will enable our seniors to remain independent in their own homes and communities for as long as possible.

The Act and the services network is one of our Nation's great success stories. The network has built the foundation of our Nation's systems of home- and community-based care, and it reaches into every community and serves over 8 million seniors and almost 1 million family caregivers each year.

The network has also fulfilled the intent of the Act to use the Federal investments to leverage other funds and to integrate services. For every dollar we invest in the Act, the network leverages about 3 additional dollars in public and private support. Today, the network is managing a total of about $4 billion in funding, making it the largest provider of home- and community-based services in the Nation.

The network has been playing a major role in the transformation of Medicare, and this has been most visible in our partnership with the Centers for Medicare and Medicaid Service (CMS) to provide community-level education, outreach and personalized assistance to millions of seniors during the campaign. The network supported over 84 percent of the 49,000 events that were held at the community level.

The modernization of the programs under the Older Americans Act is my number-one priority. I am guided in this effort by the President's New Freedom Initiative, by input from our consumers and key stakeholders, and through our network's innovations in rebalancing State and local systems of care.

Senator Smith, as you well know, it was the aging network in your own home State of Oregon that led the way for the rest of the Nation over 15 years ago when it successfully redirected Medicaid funding for long-term care and created a more balanced system where half of all public funding for long-term care is spent on cost-efficient home- and community-based care.

All of us have heard from consumers, both older and younger alike, that they want to remain at home. But our system is still biased in favor of expensive institutional care. People find it very difficult to learn about and access lower-cost alternatives.

We have implemented several projects in this area for the last five years to help modernize our programs and improve their efficiencies so we can help seniors remain at home. Of particular note, I want to call attention to the map that we have on display.

We are very proud of the investments that we have done jointly with the Centers for Medicare and Medicaid Services in establishing our aging and disability resource centers. They were designed to really help States make it easier for consumers to learn about and access services through a one-stop-shop kind of entry point to long-term care. We are currently supporting over 100 local ADRC projects in 43 States.

We launched the "Own Your Own Future Campaign," together with CMS, the National Governors Association and others, to educate individuals on the importance of planning ahead for one's long-term care. To date, we have reached nearly 4 million consumers in nine States.

We are also working with the Centers for Disease Control and Prevention (CDC) in 20 States to deploy evidence-based prevention programs at the community level that have proven to be effective in reducing the risk of disease, disability and injury among the elderly.

We are using consumer-directed models of care to put consumers in the driver's seat when it comes to making decisions about the type of care they receive and the manner in which they receive it.

I was thrilled to see this Committee and the rest of Congress for how, in a bipartisan effort, they embraced the key elements of the modernization and efficiency agenda in the reauthorization of the Older Americans Act in 2006.

Our priority for the FY 2008 budget is to maintain our core programs, improve the flexibility to the States and local communities and further strengthen the efficiency and modernize the way that we do business for consumers.

Data has shown that the services we are providing are effective at helping people to remain at home longer and to participate more fully in community life. Overall, our core programs are very customer-friendly, but, most importantly, our data show that customer satisfaction rates exceed 85 percent for all of our key programs.

Our FY 2008 budget also includes $28 million for our Choices for Independence demonstration. This request will allow us to move forward and evaluate our modernization efforts so we can document their impact on the health and well-being of older people, and on Medicare and Medicaid costs.

In closing, I would like to note that, under the leadership of President Bush, we have initiated the modernization and improved efficiency of health and long-term care in the United States, in partnership with many of the Members on this Committee.

Last year, the President stated, we've got to have an interesting debate in health care in America. I guess if I had to summarize how I view it, I would say there is a choice between having the government make decisions or consumers make decisions. I stand on the side of encouraging consumers. Health care policy ought to be aimed at bolstering the consumer empowering individuals to be responsible for their care decisions.

That is the key strategy we are using to modernize and prepare our programs for the challenges of the 21st century and to do it in a fiscally responsible manner. We are putting our consumers front and center.

Thank you for the opportunity to participate today. I have appreciated the Committee's support for all our programs in the past and look forward to continuing to work with you in the future. I would be happy to answer any questions.

[The prepared statement of Ms. Carbonell follows:]

STATEMENT OF

JOSEFINA CARBONELL

ASSISTANT SECRETARY FOR AGING

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ON

FEBRUARY 15, 2007

Chairman Kohl, Senator Smith, Members of the Committee, thank you for the invitation to discuss the Administration on Aging's priorities, including our budget request for Fiscal Year 2008. I am honored to share this panel with my colleague Leslie Norwalk from the Centers for Medicare and Medicaid Services (CMS), Michael Astrue of the Social Security Administration (SSA), and Brian Montgomery of the Department of Housing and Urban Development (HUD).

Before I discuss the specifics of our budget request, I would like to talk about the broader policy and programmatic context and thinking that shaped the development of our priorities and our budget.

As Leslie Norwalk stated so well, we are witnessing sweeping and fundamental transformations in the way we think about and deliver health and long-term care in this country.
All of these changes are happening at a time when we are experiencing unprecedented growth and diversity in our aging population. Last year, the first wave of America's 78 million Baby Boomers began turning age 60. Every seven seconds today, and for the next 20 years – someone in America will reach this milestone.

To help prepare our nation for these changes, the Administration on Aging (AoA) has been working hand-in-hand with CMS for five years now to modernize the services we provide to the population we jointly serve. Medicare, Medicaid and the Older Americans Act (the Act)

represent a cornerstone of our nation's commitment to the health and well-being of our older citizens and people with disabilities of all ages. These programs are designed to complement one another, so it is critical that AoA and CMS coordinate our efforts to modernize these programs for the benefit of the people we serve – and, that is exactly what we have done.

I had the privilege of administering Older Americans Act programs at the community level for many years before the President honored me by appointing me to serve as the Assistant Secretary for Aging. I believe the Older Americans Act is one of our nation's great success stories.

The framers of the Act anticipated the growth in our older population, and charted out a bold vision for a nationwide network of public and private agencies and organizations focused on a common mission -- to ensure the dignity and independence of older people. The Act charged this aging services network with the responsibility to promote the development of a comprehensive and coordinated system of home and community-based services that will enable our seniors to remain independent in their own homes and communities for as long as possible. This system of services includes information and personalized assistance; access to a broad array of benefits and services, case management, specialized transportation services, congregate and home-delivered meals, adult day care, senior centers, personal care, homemaker and chore services, health promotion, disease prevention, and supports for caregivers.

We have made tremendous progress in advancing the goals and objectives of the Act through the combined efforts of the aging services network consisting of 56 State units on aging, 655 area

agencies on aging, 234 Tribal organizations, 29,000 community-based aging services provider organizations, and one-half million dedicated volunteers.

The aging services network has literally built the foundation of this nation's formal system of home and community-based care. And we have done it in partnership with older Americans and their families.

As a result of our investments in the Older Americans Act, we now have a nationwide infrastructure in place that reaches into every community in this country and serves over eight million seniors and close to one million family caregivers each year. We are strengthening America's families and our services aim to keep people who are chronically impaired out of nursing homes. We also aim to keep older people healthy and engaged in community life.

Consistent with the original intent of the Act, the aging services network has successfully used our Federal investments to leverage other funds and integrate services. The Older Americans Act was not designed to support a free-standing system of services. OAA funds are to be used strategically to advance changes in our overall system of care, and to fill gaps in services. The network has done an outstanding job in meeting this intent. For every dollar we invest in the Act, the network leverages about three additional dollars in public and private support. Today, using $1.3 billion in Federal support, the network is managing a total of $4 billion in funding, making it the largest provider of home and community-based services in the nation.

As Leslie Norwalk noted, the aging network has been playing a major role in the transformation of Medicare. This has been most visible in our partnership with CMS to provide education,

outreach, and individualized assistance to millions of seniors during the Medicare Part D Outreach and Enrollment Campaign. In many of these events, we were also joined by our partners at SSA. The aging services network took the lead in convening and/or supporting over 84 percent of the 49,000 events that were held at the community level as part of the CMS led campaign between January 1, 2006 and May 15, 2006. AoA and CMS also jointly funded 340 community-based outreach project targeted specifically at hard-to-serve, limited English speaking, minority and disabled beneficiaries. Many of our local aging network organizations have had excellent working relationships with the Social Security field offices. As a result, our efforts to inform beneficiaries about Part D and the Part D low-income subsidy were also enhanced by our strong working relationship with SSA.

Our success in Medicare Part D proved what consumers and their caregivers already know: the aging services network is a visible, on-the-ground presence at the community level all across our nation. The network is relied on and trusted by America's seniors and is highly effective in reaching older people where they live, work, play and pray.

Senator Smith, as you know, it was the aging services network in Oregon that led the way for the rest of the nation over 15 years ago when it successfully redirected Medicaid funding for long-term care, and created a more balanced system where half of all public funding for long-term care is spent on home and community-based care. The aging network in the State of Washington followed suit and did the same thing with that State's long-term care system. In the States of Wisconsin and Vermont, the network has played a key role in integrating services, and both of these States are now using models that combine nursing home and community-based resources

into flexible services models. These innovations are enhancing consumer choice and community care.

Two-thirds of States have given their State units on aging responsibility for managing one or more of their Medicaid waivers. And in more than half the States, the aging network has been charged with the responsibility to serve other populations, including younger people with physical disabilities and people with developmental disabilities.

Our Older Americans Act network is making a real difference in the lives of people every day all across this nation. However, if we are to continue to be successful, we must keep pace with the changes occurring in the larger policy environment.

Modernizing Our Core Older Americans Act Programs

When I was appointed Assistant Secretary for Aging, I made the modernization of the Older Americans Act programs my number one priority, and I was guided by the President's priorities in long-term care outlined in his New Freedom Initiative. I also looked to the Act, and to our core Older Americans Act programs. And most important, I got input from our customers and key stakeholders, our seniors and their caregivers, and members of the aging network, from all across the nation.

We heard from consumers-both older and younger alike-that they want to remain at home. We also heard loud and clear that our system is still biased in favor of expensive nursing home care, and people are generally not aware that lower cost options are available or find it extremely

difficult to access these alternatives. Many Americans still think Medicare pays for long-term care.

We have also implemented several demonstration projects on long-term care. For example, we rolled out the Aging and Disability Resource Centers (ADRCs) in 2003 in partnership with CMS. Through ADRCs, we aim to help States re-engineer their systems of consumer information and access through the establishment of "one-stop-shop" entry points to long-term care. Our goal is to make it easier for consumers to learn about and access services that are available to them in their communities. Just as the network helped to bring transparency to health care in Part D, we are now bringing transparency to long-term care through our ADRCs. The ADRCs require strong partnerships at the State level between the aging, Medicaid and disability agencies with the governor appointing the lead agency. Effective partnerships, with the involvement of all public and private stakeholders, help to ensure that the ADRCs can breakdown multiple barriers for consumers, including fragmented and complex funding streams with duplicative intake and eligibility processes. We are currently supporting ADRCs projects in over 100 communities in 43 States serving both those in need of public resources like Medicaid as well as individuals using private resources.

In 2004, with Assistant Secretary for Planning and Evaluation (ASPE), CMS, the National Governors Association and selected States, we launched a complementary initiative, the "Own Your Future Campaign" to educate individuals on the importance of planning ahead for one's long-term care. To date, we have reached nearly 4 million consumers over the age of 45 in nine States, and we are expanding this Campaign to five additional States later this year. As part of

this campaign and the new reforms under the Deficit Reduction Act, we also launched a new website this past December at www.longtermcare.gov. This is the first Federal website specifically designed to help people plan ahead for their long-term care.

To modernize our core Older Americans Act programs in the area of health promotion, we rolled out a joint initiative program in 2003 to put the best available science into the hands of older people who are at-risk of chronic disease and disability so they can take more control of their own health. Working with the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the National Institute on Aging, CMS and several major national foundations, we are helping our aging services provider organizations, such as senior centers and faith-based organizations, to deploy evidence-based prevention programs that have proven effective in reducing the risk of disease, disability and injury among the elderly. These interventions involve simple tools and techniques seniors can use to better manage their chronic conditions, reduce their risk of falling, and improve their nutrition and their physical and mental health. This initiative was started in 12 communities, and we expanded with support from the Atlantic Philanthropies. We are now gearing up projects in 20 States. Like ADRCs, our long-range vision is to eventually see evidence-based models being offered through our core Older Americans Act programs in every community.

To promote the use of flexible, consumer-directed models for high-risk individuals, in 2004 we joined ASPE, CMS and the Robert Wood Johnson Foundation to support the replication of the Cash and Counseling model that was successfully tested in the States of Florida, Arkansas and New Jersey. This model puts consumers in the driver's seat, when it comes to making decisions

about the types of care they receive and the manner in which they receive it. This approach has been extremely popular among consumers, young and old alike, and has been shown to be effective at helping high-risk individuals to stay at home. Together with our partners, we are helping 11 States to replicate this program into their home and community-based waivers. Our aging services network led the implementation of the Cash and Counseling model in 2 of the 3 original States, and is now leading 8 of the 11 replication projects. Using flexible service models and giving people more control over their care is going to require us all to think very differently about how we deliver services and measure quality. We have to begin to let our Older American Act dollars follow people's needs, not service categories. We must do this to remain effective at promoting consumer-driven systems of care. This approach will also help our network respond to the growing number of seniors who will be able to pay for the cost of the services they receive.

I was thrilled to see the Congress embrace the key elements of our modernization agenda that I just described as part of the reauthorization of the Older Americans Act in 2006. These elements were reflected in the Administration's Choices for Independence demonstration project. In December, we took our first major step to implement the new amendments by convening a national summit here in Washington. The summit brought together over 1,300 people from all parts of our network for a peer-to-peer exchange of best practices, strategies, and tools that State and local governments and community-based organizations can use to help older people remain healthy and independent. It focused on the three elements of our modernization strategy that I have talked about this morning. By all accounts, the summit was extremely well received by our network.

FY 2008 Budget Proposal

I now want to discuss the investments we want to make in 2008. Our priority for making the budget was to maintain our core programs, improve their flexibility, and to further strengthen and modernize them and the aging services network.

For FY 2008, AoA's request maintains core program funding at the FY 2007 President's Budget level of $1.268 billion, which will allow us to continue providing high-quality, effective services to seniors and their caregivers. When used together in response to defined consumers needs, these core programs provide greatly needed services and cost-effective long-term care alternatives that enable seniors to stay at home.

These services include:

- over 20 million hours of in-home services such as homemaker, chore and personal care;
- over 240 million meals in home and community-based settings,
- over 10 million units of services for over 700,000 caregivers and,
- 36 million rides to doctor's offices and other critical daily activities.

Our outcome survey data show the array of services provided are effective at helping people to remain at home longer, and to participate more fully in community life:

- 45 percent of seniors using transportation services rely on them for "virtually all" of their needs – without these services, these individuals would be homebound.

- 43 percent of seniors receiving homemaker services report a level of frailty consistent with that of nursing home residents.
- 91 percent of home-delivered meal recipients report that the meals enabled them to continue living in their own homes.
- 84 percent of the caregivers say that OAA services enabled them to continue to care for their love ones longer; and
- Consumer satisfaction rates exceeded 85 percent for all core service programs in 2005.

To improve our accountability to our consumers, we have set ambitious performance targets for our key program measures of efficiency, outcomes, and targeting as part of our integrated performance budget. For example, we have increased the number of seniors served per million dollars of AoA funding over the last five years by 22 percent.

In FY 2008, our goal is to continue to increase this efficiency while maintaining high-quality services for those most in need. We aim to test whether our investments in Aging and Disability Resource Centers, consumer directed care, and evidence-based programs, all part of the proposed Choices for Independence demonstration, will lead to continual improvements that will help us to achieve our ambitious goals and better serve our nation's seniors and their families now and in the future.

Choices for Independence Demonstration:

Our FY 2008 budget includes $28 million for our Choices for Independence demonstration. This request will allow us to move forward with and evaluate our modernization efforts so we can document their impact on the health and well-being of older people, and on Medicare and Medicaid costs. This will include testing the provision of flexible, consumer-directed services under the Older Americans Act that will be targeted to individuals who are at high-risk of nursing home placement and spend down to Medicaid.

The principles that comprise Choices for Independence include:

- Making it easier for people to learn about and access existing health and long-term care options that are available to them in their communities, including options that will enable people to plan ahead for their long term care;
- Empowering seniors, including seniors who are already impaired, to make behavioral and lifestyle changes that can improve their health and reduce their risk of disease, disability and injury; and,
- Enabling seniors who are at high-risk of nursing home placement to remain at home through the use of flexible service options.

Opportunities for the Future

Under the leadership of President Bush, we have initiated the modernization of health and long-term care in the United States. In August of last year, the President stated:

> "We've got an interesting debate in health care in America. And I guess if I had to summarize how I view it, I would say there's a choice between having the government make decisions or consumers make decisions. I stand on the side of encouraging consumers.... And health care policy ought to be aimed at bolstering the consumer, empowering individuals to be responsible for their…care decisions."

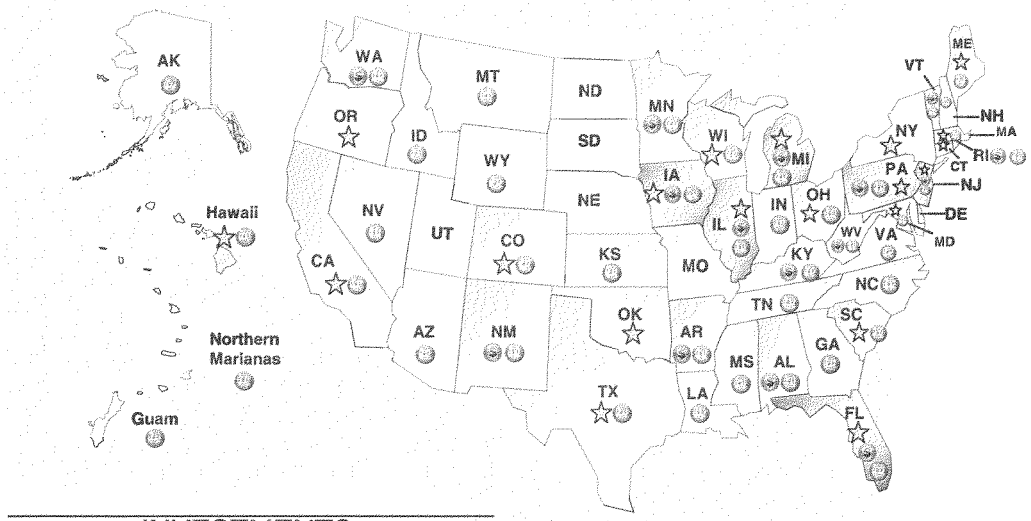
The President's words reflect the central thrust of the strategy we are using to modernize our Older Americans Act programs. Our strategy focuses on empowering our consumers by giving them more choices and greater control over their own health and long-term care -- including more control over the types of benefits and services they receive, and the manner in which those benefits and services are delivered. We are helping people to conserve and extend the use of their own resources, including helping middle-aged individuals to plan ahead for their long-term care. We are also empowering seniors to make science-based behavioral changes that will improve their health and well-being. And we are looking at new ways of targeting our limited resources at seniors most in need.

I believe putting consumers front and center is the best way to ensure our success in modernizing our Older Americans Act programs and the aging services network for the 21st century.

Thank you for the opportunity to participate in today's hearing. I have appreciated the Committee's support of AoA in the past and I look forward to working with you in the future. I am happy to answer any questions that you may have.

# ADMINISTRATION ON AGING

## Modernizing Older Americans Act Programs




INVESTMENTS

- Evidence Base Disease Prevention Projects
- Cash & Counseling Demonstration Programs
- Aging & Disability Resource Center Initiatives

State Involvement in all 3 Program Components; 2 Program Components; 1 Program Component

Senator SMITH. Thank you very much, Josefina. I will have some questions for you in written form.

Brian, can you give us the abbreviated version?

**STATEMENT OF BRIAN MONTGOMERY, ASSISTANT SECRETARY FOR HOUSING, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, WASHINGTON, DC**

Mr. MONTGOMERY. Yes, sir. You saw me crossing as she was writing. [Laughter.]

I want to thank you for the opportunity to——

Senator SMITH. We will include it all in the record, though.

Mr. MONTGOMERY. OK. Thank you, Senator.

I also want to thank Chairman Kohl for the opportunity to address HUD's efforts in this area.

Let me be clear with one fact: The senior population today represents a greater portion of the overall population than at any time in our history. I want to add that that number is not on the decline. As such, the housing needs of seniors are ever-increasing and ever-expanding.

Not only does the baby-boomer generation have strength in numbers, but many also have considerable wealth and are active participants in the democratic process. They are living longer and more active lives than previous generations. Many have the resources to manage their own retirement. They have an undeniable common voice.

Unfortunately, however, the resources necessary to answer the needs of the growing senior population are not always available. In an effort to better illustrate this need, let me provide you with some senior housing statistics.

Of the 21.8 million households headed by seniors in 2001, 80 percent were homeowners and 20 percent were renters. Approximately 73 percent of senior homeowners own their homes free and clear. The median net worth of elderly households in 2000 was almost $189,000, compared to $55,000 for the total population.

Now, 80 percent of seniors being homeowners may sound good, but the remaining 20 percent, or 4.3 million, are renters. We simply are not producing the necessary affordable housing at a pace that adequately reflects their needs.

Our own data from 2003 estimates that there are over 1 million senior renters experiencing worst-case housing need, generally defined as people without housing assistance paying more than half of their income for housing or living in severely substandard housing. In short, this Nation is facing a shortage of housing assistance for low-income senior citizens.

Now, in a highly competitive budget environment, we are pursuing creative and innovative ways to address the housing population facing the elderly, and that would include the low-income renters and also many seniors who are considered house-rich but cash-poor.

Harvard University's "State of the Nation's Housing" report in 2002 found that 8.4 million of the Nation's 21 million elderly have incomes of less than $10,500. Now, the median income for a resident in a HUD Section 202 project is only $9,480 a year.

As you may know, HUD's Section 202 program provides an important resource to address the housing needs of low- and very low-income seniors. However, consider this alarming fact. AARP estimates that there are 10 seniors waiting for each Section 202 unit that becomes available.

The bottom line here is that in order to meet the need we have to be able to build more units, and we have to be able to build them faster.

Since the inception of the Section 202 program, there have been roughly 400,000 units funded, or an average of 8,300 per year. Now, in order to meet the need as identified in a Commission on Affordable Housing study, we would need to produce more than 56,000 units per year over the next 13 years.

Well, in order to help reach these goals, we need to find creative and resourceful ways to increase production. As such, the fiscal year 2008 budget proposes an innovative demonstration program aimed at increasing the production of Section 202 units.

We developed this program for a number of reasons. Chief among them, of course, is the sheer growth of the population in question. Additionally, the cost of construction is ever-increasing, as is the need to renew rental assistance contracts on these projects. That need for renewal in itself will continue to erode the funding available to produce additional units.

Now, this demonstration project will seek to utilize low-income housing tax credits and other housing resources, such as tax-exempt bond financing, home program funds and even private grants, to help expand production under the current 202 program. It is our goal to take the positives from the housing tax credit and 202 program and produce vastly more units with strong senior services components.

Finally, for seniors who have accumulated assets in their home, we have the Home Equity Conversion Mortgage, or HECM, for short, also known as a reverse mortgage. It is designed to enable senior homeowners to convert the equity in their homes into tax-free income.

Now, since fiscal year 2000, when we insured just 6,600 loans, the HECM program has been experiencing double-digit growth each year. In fiscal year 2005, we endorsed 43,000 loans, representing a 14-percent increase over the prior year. In fiscal year 2006, volume really exploded. It increased by 77 percent to more than 76,000 loans. Endorsements continue to accelerate with nearly 35,000 so far this fiscal year, which puts us on a pace to insure about 90,000 loans.

We are also proposing legislative changes that would enhance this very important program, which includes eliminating the current cap altogether and offering a home purchase alternative.

Senator SMITH. Brian, I apologize, but——

Mr. MONTGOMERY. Yes, sir.

Senator SMITH [continuing]. This pink slip is about to get red. [Laughter.]

Mr. MONTGOMERY. Thank you, sir.

[The prepared statement of Mr. Montgomery follows:]

# STATEMENT OF BRIAN D. MONTGOMERY

Assistant Secretary for Housing – Federal Housing Commissioner
U.S. Department of Housing and Urban Development

Hearing before the Special Committee on Aging

United States Senate

February 15, 2007

Good morning, Chairman Kohl, Ranking Member Smith and distinguished Members of the Special Committee. Thank you for the opportunity to testify on the efforts made by the Department of Housing and Urban Development to address the housing needs of America's seniors. As the Committee is aware, the Department has a long-standing history in providing affordable housing and delivering related services to one of the nation's most vulnerable populations, low- and very-low income seniors.

Recent studies highlight the overwhelming growth of this population and thus their corresponding affordable housing needs. It is important to note that there is an overwhelming amount of data proving:

1.) Baby Boomers will remain active and independent longer than previous generations;
2.) Many of them have wealth to manage retirement like no previous generation has; and
3.) As voters, they are going to challenge how America's seniors will be treated.

I am certain that this Committee is well aware of senior population growth patterns so I will not recite those statistics. I will get right to the housing related facts.

Of the 21.8 million households headed by seniors in 2001, 80 percent were owners and 20 percent were renters. Approximately 73 percent of senior homeowners owned their homes free and clear. The median net worth of elderly households in 2000 was $188,885 compared to $55,000 for the total population. Eighty percent of seniors being homeowners may sound good, but the remaining 20 percent – or more than 4.3 million – are renters, and we simply are not producing the necessary affordable housing at a pace that adequately reflects their needs.

Our own data from 2003 estimates that there are over one million senior renters experiencing worst case housing need, generally defined as people without housing assistance paying more than half of their income for housing or living in severely substandard housing. In short, this nation is facing a shortage of housing assistance for our low-income senior citizens.

I am here today to talk about existing and potential housing opportunities for America's seniors, both for those who have the above-mentioned wealth, and more importantly for those who do not. Meeting the housing needs of America's seniors is one of our top priorities at HUD – and, as you will hear, we are creating new and innovative ways to achieve success.

To adequately address the housing needs of this growing population, it is estimated by the congressionally-established *Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century*, that an additional 730,000 rent-assisted units will be needed by 2020 to house seniors with housing problems (*cost burden*) age 65 and older.

Harvard University's report, *State of the Nation's Housing 2002*, found 8.4 million of the nation's 21 million elderly have incomes of less than $10,500 a year. The median income for a resident in a HUD Section 202 project is $9,480 and that resident is more than likely female. As you all may know, HUD's Section 202 program provides an important resource to address the housing needs of low- to very-low income seniors. However, the program in its current state only addresses a small percentage of senior housing needs. Consider this alarming fact: AARP estimates that there are ten seniors waiting for each Section 202 unit that becomes available.

The Section 202 program makes a significant contribution to addressing seniors' housing needs by providing affordable housing units, many with supportive services. Today's Section 202 program is, simply put, a capital advance (*or construction*) program with project rental assistance. The capital advance is provided without interest and does not have to be paid back as long as the housing remains available for the intended population for 40 years. Projects developed under the current program also provide supportive services dependent upon the needs of the residents.

However, the overall aging of the population and the commensurate need for senior housing has prompted HUD to make some changes in a variety of our programs, including Section 202.

I want this committee to know that this Administration and HUD share your concerns regarding senior housing needs. We are committed to the ongoing viability of the Section 202 program.

Based on the funding appropriated each year, more than 20,000 new units of Section 202 housing units have been approved since the Department last appeared before this Committee in 2003. The proposed FY 2008 budget will provide $575 million in funding for the Section 202 program. This is a net increase of $30 million more than last year's request. This funding will provide: construction of new units, congregate services, service coordinators, funding to convert projects to assisted living, and funds to renew and amend existing contracts.

In the FY 2008 budget, the Department has proposed an innovative demonstration program aimed at increasing the production of Section 202 units. Between 1995 and 2005, we witnessed Section 202 production decline by approximately 40 percent despite relatively stable appropriations. One of the main reasons for the recent decline in development is that as rental assistance contracts expire, they are renewed from the same pot of funds that would otherwise be targeted toward development. In the future, as a larger proportion of the appropriation is taken up by rental assistance, there will be less available for new development.

To help stop the decline and, moreover, increase unit production, HUD's FY 2008 budget calls for $25 million for a demonstration project that will seek to utilize housing tax credits and other housing resources (tax-exempt bond financing, HOME Program, private grants, etc.) to expand production under the Section 202 program.

It is commonly known that housing tax credits produce a vast number of units nationwide. In fact, according to the AARP study, as of 2003 more than 1.1 million units for low-income individuals and families had been produced using housing tax credits. It is our goal to take the positives from both and produce vastly more units with strong senior services components.

To prepare for this likely demonstration project, we have contracted with experts in the field (industry stakeholders, housing advocates, etc.) to look at various ways to improve the program. Some of the areas currently being researched include:

- Identifying ways to complete projects in a timelier manner, utilize various funding sources to expand the impact of the limited 202 dollars, and provide enhanced supportive services;

- Identifying and removing barriers in the Section 202 Prepayment and Refinancing Program to facilitate the preservation and rehabilitation of existing properties; and

- Identifying ways in which HUD can partner with other federal, state, and local agencies to leverage the Section 202 funds.

We anticipate the completion of the study in the Spring of 2007 and anticipate a Notice of Funding Availability (NOFA) for the demonstration program to be issued in 2008.

As I mentioned, we face two unique senior housing challenges: housing seniors of limited means, as I just addressed, and housing those with some level of accumulated assets.

HUD, through the Federal Housing Administration (FHA), has a reverse mortgage insurance program that targets senior homeowners. The Home Equity Conversion Mortgage, or HECM for short, is designed to enable senior homeowners to convert the equity in their homes into tax-free income. FHA-insured mortgages account for over 90 percent of the reverse mortgage market.

Homeowners who are 62 years or older and have a paid-up or low mortgage balance are eligible for a reverse mortgage loan. Many seniors utilize the income to supplement their Social Security, meet unexpected medical expenses or make home improvements. It is also an option for Baby Boomers nearing retirement, who realize they may not have enough income to provide for a comfortable lifestyle.

Seniors can choose to receive the proceeds from a reverse mortgage all at once as a lump sum, fixed monthly payments (for up to life), as a line of credit, or a combination of these. The most popular option – chosen by more than 60 percent of borrowers – is the line of credit, which allows you to draw on the loan proceeds at any time. The borrower is not required to repay the loan until he or she no longer uses the home as a primary residence.

The HECM program started as a demonstration program in 1990 and was seen as a true innovation in the mortgage industry, a way of helping seniors who were house rich but cash poor. The program became permanent in 1993.

Because FHA recognizes that seniors with considerable equity in their homes can be prime targets for predatory lending, we require that seniors considering a HECM loan receive counseling, and we have worked hard to ensure this counseling is of high quality.

According to demographic data on new HECM borrowers over the three years beginning with FY 2004, the median borrower age is 73. Half of the borrowers are between 68 and 78 years old. Another 25 percent are 79 and over.

The program once served primarily single women, presumably widows, who had very little or no income and nowhere to turn for help. These "house-rich, cash-poor" widows took out reverse mortgages to obtain money to live. The program was perceived as a last resort for individuals who had no alternative but to take equity out of their homes. What we are finding now is that the program has slowly shifted over the past decade, to attract more couples with higher incomes and more expensive homes.

Since FY 2000, when we insured just 6,600 loans, the HECM program has been experiencing double-digit growth each year. In FY 2005, FHA endorsed over 43,000 loans, representing a 14 percent increase over the prior year. In FY 2006, volume really exploded: it increased by 77 percent to more than 76,000 loans. Endorsements continue to accelerate, with nearly 35,000 so far this fiscal year, in which we ultimately expect to insure about 90,000 loans. Despite this astounding growth, the National Reverse Mortgage Lender Association estimates that these numbers represent a two-percent of the universe of possible borrowers.

FHA uses underwriting criteria that allow us to operate the program without the need for appropriations of credit subsidy. Because of the long-term nature of these loans and the uncertainty that comes with projections of life expectancy and house price appreciation over such periods, we will remain diligent in assessing the credit risk associated with these loans.

The Department and our industry partners are excited about this growth. However, the HECM program is facing an immediate crisis. Currently, there is a statutory limit on the number of loans FHA can insure. That limit is 275,000 and we reached it on February 13. We are working with the Appropriations Committees to secure a temporary increase, but our ultimate goal is to lift the cap altogether. The program has been tested for over 15 years now and has proven to be not only successful, but a model for the reverse mortgage industry. As part of our 2008 Budget, we are proposing that the cap be altogether eliminated.

We also are proposing another legislative change that would permit HECMs for Home Purchase. One of the best ways to serve seniors well is to permit them to move to alternative housing, whether it's a senior community that offers appropriate amenities and services or simply a smaller, easier-to-maintain home. Our HECM program shouldn't

just allow seniors to take cash out of their current homes, but should permit them to move to housing that better meets their needs as they age. A change to the statute would permit FHA to offer a HECM product that would enable seniors to purchase a home and tap into the equity in their old one in a single transaction.

I would be remiss, Mr. Chairman, if I did not point out in my testimony that there a number of programs within HUD, but outside of Office of Housing, that serve the housing needs of seniors. There is the Section 8 voucher program, 17 percent of which is utilized by people over the age of 62, and public housing, 32 percent of which is used by this age group. Together, these two programs represent more than two-thirds of the Department's overall budget. Also, both the HOME Investment Partnerships Program and the Community Development Block Grant are administered in a manner that provides state and local governments the flexibility to prioritize local needs, including increasing and supporting affordable housing units for low-income seniors.

In closing, I would like to reaffirm the Administration's and HUD's commitment to aggressively seeking ways to better address the needs of this nation's seniors – we owe them that. I have only touched on a few of the components of our senior housing strategy, but I look forward to having the chance to work with this Committee in the future.

Thank you, Mr. Chairman, and I would also like to thank the Committee for the opportunity to meet with you today to discuss these important issues.

Senator SMITH. We will put it all in the record.

I thank our witnesses. I thank you all for your attendance. I apologize that the leadership doesn't check with me on the voting schedule. [Laughter.]

So, with that, we are adjourned.

[Whereupon, at 10:44 a.m., the committee was adjourned.]

# APPENDIX

QUESTIONS FROM SENATOR SMITH FOR MICHAEL ASTRUE

*Question.* With respect to your FY 2008 request for SSA administrative resources, what assurances can you provide me that SSA will be adequately funded to effectively meet its many obligations?

Answer. SSA's budget is based on the level of resources needed to improve service delivery and fiscal stewardship, and the requisite staffing to accomplish both. The budget is aligned with the performance goals in the Agency Strategic Plan, demonstrating the resources required to maintain service and improve productivity.

SSA's first and foremost priority is service. This budget request allows SSA to generally maintain service, increase our program integrity efforts, and continue to meet Medicare prescription drug program responsibilities. However, there will be some growth in certain pending workloads in fiscal year (FY) 2008. SSA will also continue to improve the way it does business with investments in technology, such as the Electronic Disability (eDib) project. Given significant reductions to our budget requests over the last 6 years, it is critical that Congress fully fund the FY 2008 President's request for SSA.

*Question.* We're in a very tight budget environment—what things can you do to advocate for adequate funding for SSA?

Answer. I have been reviewing SSA's workloads as Congress requested at my confirmation hearing and plan to present to the Congress my planned changes for the disability program as well as the resource needs to make sure the budget will be funded to prepare for the initial retirement wave of baby boomers.

I can assure you that I will continue to inform the Congress and the American public about the need for adequate funding for SSA's administrative expenses by demonstrating the direct relationship among resources, performance and service to the public. Adequate funding will enable us to reduce the backlogs for initial disability claims and hearings. Funding at the President's budget level would also allow the Agency to fund program integrity activities, such as continuing disability reviews and Supplemental Security Income redeterminations, at a more appropriate level.

I expect to work closely with this committee as well as our authorizers and appropriators to fully inform you and the public about the importance of these issues.

*Question.* What is the agency's view of the success of this transition?

Answer. Let me be clear that I am very concerned about the disability backlogs, and I have been reviewing the situation as Congress requested at my confirmation hearing. I plan to present my planned changes to revise the disability program to Congress soon. I am in the process of making some changes and in the near future will be prepared to brief staff of the committee about the changes that will be made.

With regard to the transition to eDib, while we are not completely finished with the process of converting from paper disability files to fully electronic ones, we consider this transition to be quite successful. As of January 4, 2007, all the SSA field offices and the State Disability Determination Services (DDS) in the nation have been certified to work in the fully electronic process, and currently hearing offices in 40 States and territories have been certified for fully electronic processing (the hearing office in Eugene, Oregon is scheduled for certification in May 2007). This means that these components are working solely with electronic folders for most new claims with a very small number of claims excluded from that process. We eliminated the labor-intensive process we had previously which required our field offices to prepare paper folders and mail them to the DDS for processing. With the new system, there are no mail costs, no mail time, and no possibility of folders getting lost. We anticipate that, over time, the electronic folder will result in reduced storage, mail and shipping costs; and will offer greater portability of folders to components throughout the country. While eDib is not implemented at all levels of the Agency yet, next year we plan to expand it to the Appeals Council.

The success of any project—even a technology-driven one such as the eDib project—requires a learning curve for the people who use it and depends on how well those people accept, embrace, and use it. With eDib, we asked our employees to move from a traditional, paper-based system to a fully electronic one. We invested significant time and energy to ensure that this aspect of the project would be a success. We shared information about eDib well in advance of actual implementation, spent considerable amount of time with classroom and on-the-job training, and continually followed up with refresher training. We also set up a special "Help Desk" for users to call with problems and suggested changes.

*Question.* What's being done to fix the problem?

Answer. With regard to the situation you describe in Oregon, I am pleased to be able to tell you that, currently, the disability processing time for the DDS and field office in Oregon is 1 to 2 weeks better than the national average. Although there has been a learning curve, SSA anticipates a return to pre-eDib production levels in FY 2008 and expects continued improvement in future years.

Whenever we encounter a systems problem, we immediately involve a highly-specialized technical support team to trouble shoot and solve it. And if necessary, we call in vendors if we find that the problem is related to vendor code, software, or telecommunication lines. Technical problems rarely last more than a few minutes, and any impact to processing electronic cases is minimal. On a proactive basis, we monitor hardware, software, network traffic, and systems performance around the clock and make adjustments as necessary.

eDib provides a secure, centralized Web-based repository of medical and other documents associated with disability claims. It is a complex system that integrates 150 unique software and hardware products, as well as interfaces with numerous SSA and external systems. As you might imagine, we occasionally have technical issues which cause slowness and/or problems for the eDib system. However, the eDib system is available and working correctly a high percentage of the time. Specifically, we have maintained over a 99 percent availability rate since the beginning of FY 2007.

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QUESTIONS FROM SENATOR SMITH FOR LESLIE NORWALK

**Question 1—Part D income-sensitive premiums**

The President's Fiscal Year 2008 budget includes a proposal to index Medicare Part D premiums to a beneficiary's income. Congress enacted a similar change to Medicare Part B premiums in the Medicare Modernization Act. However, in Medicare Part B there is a single premium amount that was adjusted for all beneficiaries. Medicare Part D consists of numerous prescription drug plans, each with their own premium that reflects a policy's scope of benefits.

*Question 1.* Considering the complexity of Medicare Part D's premium structure in comparison to Part B, and given your agencies inability to correctly withhold those amounts, how does CMS expect to administer an income-sensitive premium structure without burdening beneficiaries?

Answer. CMS, working with the Social Security Administration and key stakeholders (plans, pharmacies, etc.), has made tremendous strides to resolve administrative issues encountered in the first year of the program and to lay the groundwork for continued improvements in 2007 and beyond. Those steps have clearly paid off, with a 97% acceptance rate for transactions between CMS and SSA in 2007. We are confident that the lessons learned and improved processes will allow us to design the income-related premium provision in a way that will be most efficient and administrable for affected parties.

**Follow-Up:**

*Question a.* How much money will CMS raise by eliminating the inflation adjustment for the Part B premium increase?

Answer. If the President's fiscal year (FY) 2008 Budget proposal to eliminate the inflation adjustment for the Part B premium increase were to be implemented, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) estimates that, over 5 years (FY 2008—FY 2012), Medicare will save $4.13 billion and, over ten years (FY 2008—FY 2017), $12.1 billion will be saved.

Under current law, beneficiaries filing an individual tax return with incomes greater than $80,000 and beneficiaries filing joint tax returns with incomes greater than $160,000 will pay a greater share of their costs for Medicare Part B on a sliding scale that increases as their income increases. The threshold dollar amounts to determine whether the income-related premium applies to the beneficiary and the amount by which the subsidy is reduced would be adjusted for inflation taking into consideration the consumer price index for urban consumers. Under the FY 2008

proposal, the annual indexing of income thresholds for reduced Part B premium subsidies would be eliminated beginning on January 1, 2008.

*Question b*. In 2020, what percentage of beneficiaries does CMS expect to be within that category?

Answer. The current Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) estimates are projected to 2017 and data is not immediately available for a projected period that extends to 2020. For FY 2017, OACT estimates that under the proposal 9.6 percent of the approximately 52 million beneficiaries will be affected by the elimination of the inflation adjustment versus the 6.3 percent that would be affected under current law. Therefore, 3.3 percent more of the estimated 52 million beneficiaries will be within the category affected by the Budget proposal than under current law.

**Question 2—Changing Medicaid through Administrative Maneuvers**

I am concerned that the Administration consistently attempts to use its administrative authority to rework the Medicaid program in a manner that is inconsistent with the intent of the Congress. During debate over the Deficit Reduction Act, many of the administrative proposals contained in your budget were debated and roundly defeated by Congress, yet you continue to try to circumvent the will of the Congress and advance them outside the legislative process.

For instance, I, along with many of my colleagues, remain opposed to your efforts to limit the use of intergovernmental transfers. You try to paint them as fraud and abuse, when those of us who know the program recognize that these functions are being used by states to generate much needed funding to cover millions of poor, elderly and disabled Americans. What's more, the plan amendments that allow the states to operate were approved by your agency.

*Question 2.* Your agency estimates that its proposal to restrict the use of IGTs will generate $5 billion in savings to the federal government, which likely amounts to close to $9 billion in total lost funding for the program. How will this money be made up within Medicaid so as not to result in lost coverage and access for persons currently on Medicaid?

Answer. The proposed rule is estimated to result in savings of $120 million in 2008 and $3.87 billion in 2008–2011. The proposed rule does not restrict the use of IGTs. Rather, the proposed rule was actually designed to protect health care providers. The proposed rule clarifies the definition of a unit of government and specifies that governmentally-operated health care providers are assured the opportunity to receive full cost reimbursement for serving Medicaid individuals.

Non-governmentally-operated health care providers, including many of the "public" safety net hospitals, are not affected by the Medicaid cost limit provision of the proposed rule and therefore, may continue to receive Medicaid payments in excess of the cost of providing services to Medicaid individuals within existing Federal requirements. Moreover, the proposed rule reaffirms State Medicaid financing policy requiring that all health care providers be allowed to fully retain their Medicaid payments, another provision of which clearly demonstrates the Federal government's intent to protect the nation's public safety net and its ability to continue delivering critical health care services to Medicaid beneficiaries and the uninsured. Health care providers can realize greater net revenues if State or local government sources pay for the full non-Federal share of Medicaid payments rather than shift that burden to the health care providers themselves.

Medicaid is a vitally important program that serves very vulnerable populations. Clearly the federal government must fulfill its obligations to fund its share of the cost of providing Medicaid services to the individuals who are eligible for Medicaid. However, Medicaid is a partnership with the states and both must meet their obligations to fund their share of the program. Our intent is to protect the nation's public safety net and its ability to continue delivering critical health care services to Medicaid beneficiaries and the uninsured.

**Follow Up:**

*Question a*. Has your agency evaluated the impact this change will have on the number of people who loose coverage on a state-by-state basis given this loss of revenue? If not, I would like those numbers.

Answer. The CMS Office of the Actuary does not prepare estimates on a state-by-state basis or by class of facility.

**Question 3—Medicare Part A and B cuts**

As I am sure you know, the Medicare program is expected to serve more than 44.6 million Americans in fiscal year 2008 with more than 37.3 million of these being elderly recipients. This is a cornerstone of health care for most older Americans with more than one in seven of all Americans and virtually all of the population aged 65 and over served by the program. This being the case, I am concerned about the

proposals related to Part A and Part B of Medicare. Specifically, you have proposed cutting $75.6 billion from the program.

*Question 3.* How can you ensure that the proposed cuts will not diminish the overall health care offered daily to our nation's seniors?

Answer. The President's fiscal year (FY) 2008 Budget demonstrates a commitment to improving America's health care system by further modernizing and improving Medicare and Medicaid; strengthening health care coverage for low-income and vulnerable populations; and taking steps to make health care more affordable and accessible for all. The proposals in the FY 2008 Budget are measured steps to improve the financial security and long-term stability of the Medicare program.

In its March 2006 Report to Congress on Medicare Payment Policy, the Medicare Payment Advisory Commission (MedPAC) suggested a number of strategies to address Medicare's long-term sustainability, including: constraining payment rates for health care providers, rationalizing benefits, increasing the program's financing, and encouraging greater efficiency from health care providers. Concluding that increasing efficiency is most desirable, MedPAC cautioned: "[e]ven if policymakers succeed at moving providers toward greater efficiency, they may still need to make other policy changes to help ensure that the program's financing is sustainable into the future."

In order to ensure the strength and stability of the Medicare Program, it is important to annually consider the need for a payment update and other policy changes. The update for many provider types was frozen by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and the FY 2008 Budget proposals' modest reduction to the rate of increase in payments for those providers that are currently receiving updates is a deliberate effort to rationalize Medicare payments. Even so, these proposals only slightly reduce the Medicare rate of growth from 7.4 percent to 6.7 percent over 10 years. As we seek to improve efficiency, CMS will continue monitoring the quality of care that is provided to beneficiaries.

**Follow-Up:**

*Question a.* We know that there are some providers that will not accept new patients who are on Medicare. How can you ensure that these cuts will not exacerbate that problem?

Answer. A recent GAO study found that an increasing proportion of beneficiaries received physician services and an increasing number of physician services were provided to beneficiaries who were treated. The percentage of beneficiaries reporting major difficulties in accessing physician services had remained relatively constant, and there had been no reduction in the predominant tendency of physicians to accept Medicare patients and payments. The GAO report is entitled, "Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems" (GAO–06–704), published June 2006.

**Question 4—Nursing Home Diversion Programs**

We know that most seniors prefer to age in their home—and as baby-boomers continue to age, I expect that sentiment to only grow stronger. We have heard quite a bit about nursing home diversion programs and the use of home and community based services as an alternative to institutional care. In fact, my home state of Oregon is doing a great job of keeping people in their homes and out of nursing homes.

*Question 4.* How extensive have the Department's diversion programs been and what barriers have you found in relocating nursing home residents in community based settings?

Answer. The Department is very committed to assisting States as they develop and expand programs serving individuals who are aging and individuals with disabilities in the community. One predominant vehicle that States use to provide home and community based services is Section 1915(c) Home and Community Based Services (HCBS) Waiver. There are approximately 300 HCBS waivers throughout the country serving more than one million Medicaid beneficiaries. While many States use these waivers as essential tools in the deinstitutionalization process, they are also using these waivers to stave off institutional stays. Of the nearly 300 1915(c) waivers that CMS has approved, approximately 115 are designed specifically for individuals who, without the HCBS services, would require those services in a nursing facility.

States also use services within their State Medicaid Plan to provide needed community based services, such as Home Health and Personal Care. As a result of the Deficit Reduction Act of 2005, States have additional options for the provision of community based long term care, such as Section 1915(i), HCBS as a State Plan Option, and Section 1915(j), Self-Directed Personal Assistance Services. CMS recently approved a Section 1915(i) State Plan Amendment for Iowa and a Section 1915(i) State Plan Amendment for Alabama. These initial State Plan Amendments were based on draft guidances, and several other States have expressed interest in

applying once CMS finishes the clearance process for the final guidances. These new DRA options are attractive because, in principle, nursing home diversion (preventing admissions) is preferable to after-the-fact efforts to transition nursing home residents back to community-living. Moreover, evaluation results from the Cash and Counseling Demonstration—the inspiration for 1915(j)—documented reduced nursing home use attributable to self-directed services in two of the three states. Medicaid cost savings from reductions in nursing home use among the "cash and counseling" experimental group were especially sizable in Arkansas. This may prove to be particularly effective way to promote nursing home diversion in rural states where traditional home care providers are in short supply.

An additional provision of the Deficit Reduction Act of 2005 provides significant funding ($1.75 billion) over five years (2007–2011) to enable States to help individuals move from institutional settings into the community. CMS awarded Money Follows the Person Demonstration grants to 30 States and the District of Columbia. While this funding is tied directly to deinstitutionalization, it will provide vital assistance to States in their diversion efforts in the future by building and enhancing essential community capacity. Under the demonstration, approximately half of the expected transitions are elderly from nursing homes. The actual number of individuals' targeted for transition to HCBS under this grant program is 26,251.

Under the Real Choice Systems Change Grants Program, CMS awarded $19.6 million for 33 Nursing Home Transition Grants (NFT) in Fiscal years 2001–2002. The Fiscal year 2002 grants ended on September 30, 2006. Twenty-three grants were awarded to States, and 10 grants were awarded to Independent Living Partnerships. These grants supported infrastructure development to identify and enable nursing home residents who could live in the community, with supports, to transition to home and community-based services (HCBS). In August 2006, as an evaluation of the NFT grants, RTI International completed the Final Report for the FY 2001 Nursing Home Transition Grants (17 grants). States reported that the infrastructure development these grants provided enabled 3,371 nursing home residents to transition into HCBS. In addition, States reported the diverting of into HCBS an additional 266 individuals that would have been admitted to a nursing facility.

As a percentage of all Medicaid long term care expenditures for older adults and persons with physical disabilities, spending in the community (including home health, personal care and HCBS waivers) increased to 26% in 2005, up from 16% in 1995 (Source: CMS Form 64 Reports).

Despite the tremendous efforts to serve individuals in their homes and communities, barriers still exist. The two major barriers to successful transition into HCBS are lack of affordable and accessible housing and transportation.

Other barriers identified include a lack of capacity for home and community services, including the ability of States to provide financial management services, timely access to home modifications, as well as the State's ability to address complex medical needs in community settings. In addition, the availability or the perspective of surrogate decision makers and/or guardians was also identified as a barrier. In addition to those noted above, the report revealed that the following items could also impede an individual's ability to move to the community:

- Lack of funding for case management/relocation assistance;
- Restrictive eligibility criteria for HCBS;
- Administrative and bureaucratic barriers;
- Resistance to transition by family members and nursing home staff and physicians; and
- Shortage of long-term care workers.

**Follow-Up:**

*Question a*. Does the Department have any studies, data or estimates on the number of low acuity seniors living in skilled nursing institutions that could be better served in housing with supportive services?

Answer. We do not have specific data on the number of low acuity seniors living in skilled nursing institutions that could be better served in housing with supportive services.

Medicare Part D would not be nearly as successful as it is today without the hard work of State Health Insurance Assistance Programs (SHIPs) in providing Part D enrollment assistance and counseling. In 2006, SHIPs received approximately $31 million, which is significantly less than $1 per Medicare beneficiary. I soon will be introducing legislation that will help remedy this funding deficiency and provide SHIPs an amount equal to $1 per Medicare beneficiary.

**Question 5—Funding for Part D Outreach and Counseling**

*Question 5.* What amount does the 2008 budget allocate for the SHIPs, and what amount is specifically earmarked for LIS outreach and enrollment?

Answer. The FY 2008 President's Budget Request includes $37.6 million for the National Medicare Education Program (NMEP) Community Based Outreach, of which $34.9 million is for SHIPs. This is funding for SHIP program support and direct grants to 54 SHIPS (50 States, District of Columbia, Puerto Rico, Guam and the Virgin Islands). The SHIPs provide an important role in counseling for LIS. During our 2006 SHIP grant year (April 2006—March 2007), 14,792 events were held by SHIPs where the target audience was the LIS population. As a proxy for LIS, 144,975 individuals with incomes below 150% of the federal poverty level were provided one-on-one counseling by SHIPs. This represents approximately 13% of all individuals who received one-on-one counseling from SHIPs in 2006.

Although the SHIP funding is not broken out by LIS and non-LIS categories, we will be gathering additional data from the SHIPs on LIS support. In October 2007, CMS will be receiving mid-term reports in which the SHIPs will provide data to CMS on their LIS activities, demonstrating how they serve the LIS population. CMS will continue to collect pertinent performance measurement and assessment data on SHIPs in FY 2008 and beyond.

CMS' fiscal year 2008 budget request has not been approved at this time. CMS would consider how these efforts can be supported in the future, pending funding.

**Follow-Up:**

*Question a*. Will funding be provided to the AAAs (Triple As) and Native American aging programs, which so far have not received dedicated resources to support their Medicare Part D efforts?

Answer. CMS has developed a collaborative partnership with the US Administration on Aging (AoA) to leverage the federal, State, tribal, and local partnerships called the National Aging Services Network. Through this collaborative effort, CMS is providing funding and other resources to the AoA and its National Aging Services Network to offer outreach and education, assistance, and counseling to people with Medicare at the local level. This partnership is designed to help beneficiaries make informed decisions about their healthcare, including Part D coverage options, and have greater access to affordable medications.

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QUESTIONS FROM SENATOR SMITH FOR JOSEFINA CARBONELL

*Question.* What type of analysis has your agency done to determine the amount of funding needed to allow OAA programs to just keep pace with projected population growth and inflation in FY 2008?

Answer. The Administration did not propose to cut funding for the Older Americans Act (OAA) Nutrition and Caregiver programs, but proposed in the FY 2008 President's Budget the same level of funding as proposed in the FY 2007 President's Budget.

FY 2007 Congressional funding for the OAA Nutrition and Caregiver programs occurred after the submission of the FY 2008 President's Budget.

AoA has not performed an analysis of funding relative to inflation. We recognize that as the population of seniors grows, the demand for OAA programs will increase over time—however, the OAA provides only about one-third of total national aging services network spending. The State and local agencies that make up this network have been and will continue to be very effective in leveraging funds from other sources to support community-based long term care.

AoA has addressed expectations for long-term growth in service demand through its innovative proposal for the "Choices for Independence" demonstration. The components of this demonstration, with rigorous testing and evaluation components, aim to increase the capacity of the aging services network to offer a comprehensive array of supportive services, including nutrition and caregiver services, to elderly individuals living in the community.

*Question.* How can the AoA appropriately protect seniors from financial exploitation when you aren't focusing adequate resources toward the problem?

Answer. Title VII funds are used for the Ombudsman Program and for elder-abuse prevention activity, including financial exploitation programming in States and communities. States also use Title III funds for these purposes and legal services.

The Administration did not propose to cut funding for financial exploitation programs or for Title VII across the board, but proposed in the FY 2008 President's Budget the same level of funding as proposed in the FY 2007 President's Budget.

FY 2007 Congressional funding for Title VII occurred after the submission of the FY 2008 President's Budget.

QUESTIONS FROM SENATOR SMITH FOR BRIAN MONTGOMERY

*Question.* How do you reconcile the Administration's funding for Section 202 Housing with the AARP study?

Answer. The Department is committed to addressing the housing needs of low-income elderly Americans. Even though the costs of renewing Section 8 contracts continue to take up a larger portion of the overall budget, the Department has increased funding for the Section 202 program by $30 million over last year's request. We have:

- Constructed almost 400,000 units specifically for the elderly.
- 303 projects in the construction pipeline worth approximately $1.3 billion. The projects in the pipeline will generate approximately 12,000 new housing units for the elderly over the next 2 years.
- And, we serve an additional 675,000 elderly families under other HUD rental assistance programs such as Section 8 and Public Housing.

Additionally, the Department has and will continue to have discussions with our stakeholders to develop options for dealing with this issue, especially as it relates to elderly housing. As part of these discussions, the Department is proposing $25 million for a demonstration program that will leverage federal dollars with tax credits and other mixed financing options to not only increase the number of units being constructed, but also decrease the time it takes to make them available to the elderly.

*Question.* How many people are eligible for the program, but not able to receive assistance because of the lack of funding?

Answer. According to the latest available Affordable Housing Needs Report (AHNR) issued by HUD's Office of Policy Development and Research, there were 2.144 million elderly renter households with very low-incomes (below 50 percent of the area median income) without housing assistance in 2003. Of these households, 1.129 million households had "worst case needs" for affordable housing, because they either were paying more than half their incomes for rent or they lived in substandard housing conditions. These household estimates were obtained from the American Housing Survey.

*Question.* Do you anticipate that your demonstration project will fill the unmet gap?

Answer. Since only $25 million will be available for the demonstration project, the Department does not anticipate the unmet gap will be filled. However, the Department does not believe that the number of additional units generated by the demonstration project will be a help in meeting the unmet housing need. With the demonstration project, HUD is most interested in identifying some best practices which facilitate the development of additional affordable housing.

*Question.* What are the available alternatives for the elderly who cannot find the affordable housing they need through this program?

Answer. The voucher program and other HUD programs as well as projects funded through low income housing tax credits and locally developed projects using local and state resources are all available to assist elderly households obtain affordable housing.

*Question.* What studies has HUD conducted, or otherwise considered, regarding the benefits (economic, social or otherwise) of seniors who are able to age-in-place in federally assisted housing versus moving to a higher level of care?

Answer. The Department's Policy Development and Research Office has completed a study. The study will be available to the public as soon as it has been cleared through the Department. We note that the study cites several studies that address the issues of seniors aging-in-place.

*Question.* In addition to the grants for assisted living conversions, what additional action has been taken to address this issue faced by so many of our elderly citizens?

Answer. The Service Coordinator Program continues to link elderly residents to social service resources in the community that enable the residents to remain in their units longer. Some project owners are also refinancing there older projects in order to generate funds to make needed modifications to the projects to enable residents to remain in their homes longer and/or provide additional services to the residents.

*Question.* How has HUD worked with other agencies to coordinate federal assistance in this area?

Answer. As a first step, the Department has met internally and with other agencies to inventory the current programs and services available to the elderly.

*Question.* Can you provide the Committee with an update on the status of the LEGACY Act?

Answer. The Legacy Act report has been submitted for HUD departmental clearance. The Census Bureau has reviewed the report and provided comments to HUD. The Department anticipates announcing the availability of the $4 million in appropriated funds in FY 2007 and training HUD staff before the end of FY 2007.

*Question.* How many families are in need of this type of housing?

Answer. Using the 2000 Census special tabulation data, denoted as STP–276, the report notes that 1.6 million grandparent-headed households are raising a grandchild and qualify for assistance under the LEGACY Act. An additional 1.1 million households meet the Act's definition of other "relative-headed." Therefore, there are approximately 2.7 million covered households in the United States. Many of these households are owners and/or have incomes that would make them ineligible for public assistance under the LEGACY Act. The 2000 Census shows approximately 265,000 grandparent-headed households and, at most, 225,000 other relative-headed renter households who would qualify for assistance under the LEGACY Act.

*Question.* Given that the agency didn't request funding for the LEGACY Act, do you consider this program to be a priority at the Department?

Answer. The Department considers any program that provides a resource to develop additional affordable housing units for very low-income elderly persons a priority. The Department is working towards announcing the availability of these funds in the FY 2007 Notice of Funding Availability.

*Question.* Why does the Administration want to eliminate this option for states?

Answer. It appears that this is not a HECM question but a needs test for Medicaid and the result, it would appear, is that individuals with more than $500,000 equity in their homes, would have to sell or lower that equity with a HECM. As such, it's outside our purview to address.

*Question.* What advice would you give individuals considering a reverse mortgage?

Answer. There are many issues an individual should consider before pursuing a reverse mortgage including other housing options, e.g., selling their home and using the proceeds to buy or rent a new home or moving into assisted living or other alternative housing. Considering all housing options will help to clarify which option best suits the individual's needs. Individuals should also research public benefits that may be available to help them address their particular need. For example, if an individual is seeking a reverse mortgage to pay for property taxes or do home repairs, their State or local jurisdiction may offer programs for these purposes. There may also be government programs that can also help pay for medical expenses and prescription drugs.

Individuals should also consider the costs associated with each of their housing options. While selling the too-large family home and purchasing a new senior-friendly home may seem the best solution, the cost of the two transactions may make this type of arrangement too expensive. Alternatively, the cost of a reverse mortgage is most affordable for those who stay in their homes for several years. Fortunately, the costs of HECM are completely transparent to prospective borrowers. Lenders are required by law (Truth in Lending Act) to provide a disclosure called a Total Annual Loan Cost (TALC) form, which arrays exactly how much this loan cost after 2, 4, 8, and 12 years. This document shows how the costs represent a smaller and smaller proportion of the loan over time. Another cost consideration often posed by people who misunderstand the benefits of a HECM is that seniors simply take out a home equity loan, which appears less expensive than a reverse mortgage. However, seniors need sufficient income and credit capacity to qualify for these mortgages and ultimately need to repay these mortgages, so home equity loans are often an impractical solution for cash-strapped seniors.

Finally, the individual may want to involve family or trusted friends in the decision making process. The individual may wish to think about the impact of a reverse mortgage on their heirs and estate. Whether an individual decides to discuss their consideration of a reverse mortgage with family and friends is a completely personal decision and choice.

*Question.* How prevalent is fraud in this industry?

Answer. HUD is not aware of much fraud in the reverse mortgage industry. In fact, most mortgage fraud is either "fraud for property" which is not going to happen on a HECM (FHA's reverse mortgage) since the borrower already owns the home, or "fraud for profit," which often includes a strawbuyer or an unwitting first-time homebuyer. These are not features of reverse mortgages.

But more importantly, at least with FHA's reverse mortgage product, the Department has instituted policies and procedures to provide protections for senior homeowners considering an FHA reverse mortgage. In addition to the various disclosures provided, including the Truth in Lending Act disclosure described above, HECM's require that seniors receive counseling from a HUD-approved counseling agency. In addition to exploring alternatives to a reverse mortgage and the financial implica-

tions of a HECM, counselors educate individuals on what to expect from the various entities involved in the loan process. Counselors explain to clients the standard ways for HECM borrowers to access their loan proceeds and warn clients against signing over funds to loan officers or others involved in the loan transaction.

Testimony for Submission for the Senate Special Committee on Aging

Witness Testimony for John Erickson

Thank you Ranking Member Smith and Committee Members for the opportunity to provide my testimony before the Committee. My name is John Erickson, and I am the CEO of Erickson Retirement Communities. Thank you very much for giving us the chance to testify. Erickson Retirement Communities recently sponsored a survey of seniors (age 65 and older) and leading edge Boomers (age 55 to 64), along with several focus groups, to look at seniors' and leading edge Boomers' views of and concerns about retirement.

Erickson Retirement Communities is the nation's premier model of integrated housing and healthcare for middle income seniors. Over the next five years, more than 40,000 seniors will be in the Erickson network. We are committed to improving aging services by promoting integrated healthcare and housing for seniors and investing in research and education to support the coming baby boom retirement.

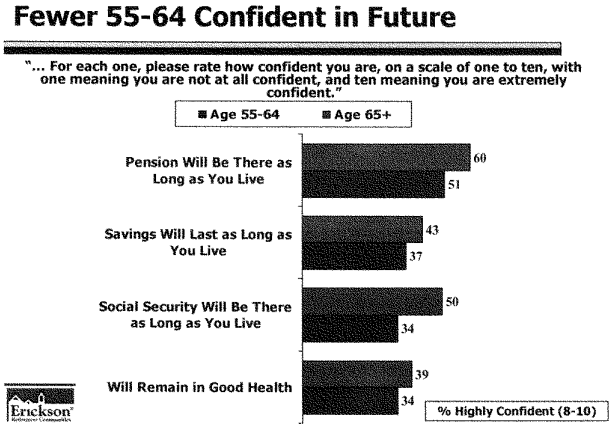
In addition to this research, Erickson is launching the nation's first cable network dedicated to seniors. Retirement Living will be the premier portal for information, entertainment, and lifestyle news for seniors.

In 2005, I launched the Erickson School of Aging Studies at the University of Maryland. The School is preparing America's next workforce for opportunities in the senior housing and healthcare economy.

Our most recent research included a survey of 800 registered voters age 55 and older conducted June 26-July 2, 2007, accompanied by eight focus groups with voters age 55 and older in Birmingham, Alabama, Bala Cynwyd, Pennsylvania (Philadelphia Suburb), Columbus, Ohio, and Springfield, Missouri.

The findings were quite surprising in many areas and revealed a changing face of retirement:

- We found that the nation's leaders must avoid treating seniors as a homogeneous voting bloc. They are not motivated merely by Social Security, Medicare and prescription drugs, and leaders do not have seniors "covered" by focusing on these issues exclusively.
- Instead, survey data and focus group discussions revealed seniors' broader concerns, including homeland security and terrorism, Iraq, immigration, health care costs, abortion, and education.
- Medicare modernization did not quench thirst for health care cost relief. The price of health care is the only issue that ranked as a top retirement concern regardless of party, ideology, gender, or age.
- We also found that there is "near retirement angst" among those getting ready to retire. Fewer voters age 55 to 64 than age 65 and older express confidence about the future.




- The research also uncovered that the seniors of today are not the seniors of our parents' generation. "80 is the new 60". Those surveyed and focus group participants firmly believed that people are healthier than they were in the past. They say they are "On the go all the time". People have an attitude of being younger and think of themselves as younger than they actually are. As long as they can make a contribution, they say they will stay vibrant and seek ways to cycle in and out of the workforce and leisure activities. 79% of people 55 to 64 and 71% of people 65 and older say that they are healthier than or as healthy as they thought they would be. Seniors say they are ready to contribute to ensure a lasting American legacy.

Thank you once again for allowing me to speak here today,

John Erickson
CEO
Erickson Retirement Communities

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