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PRESIDENT'S FISCAL YEAR 2005 BUDGET FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

FEBRUARY 10, 2004

Serial No. 108–32

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

93–228 WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
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CONTENTS

	Page
Advisory of February 2, 2004, announcing the hearing	2

WITNESS

U.S. Department of Health and Human Services, Hon. Tommy G. Thompson, Secretary	11

SUBMISSIONS FOR THE RECORD

National Association of Chain Drug Stores, Alexandria, VA, statement	68
Sandata Technologies, Inc., Port Washington, NY, Stephen A. Silverstein, and Mark C. Baff, statement	72

PRESIDENT'S FISCAL YEAR 2005 BUDGET FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

TUESDAY, FEBRUARY 10, 2004

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 2:10 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 02, 2004
FC–13

CONTACT: (202) 225–1721

Thomas Announces Hearing on President's Fiscal Year 2005 Budget for the U.S. Department of Health and Human Services

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on the President's Fiscal Year 2005 Budget for the U.S. Department of Health and Human Services (HHS). **The hearing will take place on Tuesday, February 10, 2004, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the Honorable Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On January 20, 2004, President George W. Bush delivered his State of the Union address, in which he discussed several legislative initiatives. The President provided the details of these proposals on February 2, 2004, in his fiscal year 2005 budget as submitted to the Congress. The budget for HHS included initiatives aimed at: strengthening and improving Medicare; assisting individuals who lack health insurance; and reauthorizing and improving Temporary Assistance for Needy Families, and related programs.

In announcing the hearing, Chairman Thomas stated, "This hearing will help lay the groundwork for the year's legislative business. The Committee will examine the Administration's plans to implement the landmark Medicare law that provides prescription drug coverage to seniors. We will also examine the President's proposal aimed at reducing the number of uninsured Americans," Thomas said.

"In addition, we will continue to work to ensure that the welfare reform bill passed by the House last year becomes law. Despite the dire predictions of reform opponents, the 1996 welfare reform changes have led to higher earnings for low-income parents, historic declines in child poverty, and a sharp reduction in the welfare caseload. We must support and encourage even more welfare recipients to work and must resist efforts to turn back the clock to pre-reform policies discouraging work and promoting dependence."

FOCUS OF THE HEARING:

The focus of the hearing is to review the President's fiscal year 2005 budget proposals for the U.S. Department of Health and Human Services.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person or organization wishing to submit written comments for the record must send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by close of business Tuesday, February 24, 2004. In the immediate future, the Committee website will allow

for electronic submissions to be included in the printed record. Before submitting your comments, check to see if this function is available. **Finally**, due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. If we can ask our guests to find seats, please.

Good afternoon. As we continue to explore the President's fiscal year 2005 budget, I would like to welcome once again the Secretary for the U.S. Department of Health and Human Services (HHS), Tommy Thompson. We obviously look forward to his remarks on the Administration's health care and welfare priorities.

Last year we successfully accomplished a longstanding health care goal, providing prescription drugs to seniors under Medicare. Starting in June of this year, a prescription drug discount card will be available to seniors to help reduce their out-of-pocket costs.

In just 3 months, over 100 companies have signaled to HHS their intent to offer discount cards to seniors, and I am sure we will be anxious to hear the process that the Secretary envisions for selecting those that would be able to provide this valuable service.

Further, we already are seeing the positive effects of other Medicare improvements in the new law: the revised reimbursement rates for integrated Medicare Advantage plans that resulted in lower premiums, improved prescription drug coverage, and better health care choices for seniors. We believe 93 percent of seniors in these plans will see reduced premiums; about 80 percent, reduced co-payments and deductibles; and perhaps 60 percent will receive additional benefits, including prescription drugs.

These are projections, obviously, as anyone's estimate of what is going to occur under this bill must necessarily be. However, it is pretty obvious that even with the passage of this landmark Medicare Prescription Drug and Modernization Act of 2003 (P.L. 108–173), there is more to be done on the health care front. Far too many Americans, we all know unfortunately, face health insurance as an unaffordable luxury. I am hopeful that Members of this Committee will continue to work together in a bipartisan way to assist us in the ability to provide all Americans health insurance.

Mr. Secretary, we are keenly aware of your long and strong leadership in the area of welfare reform, not just as Secretary of HHS, but as Governor of Wisconsin for more than a decade, and no one disputes the success of the welfare reform. We clearly want to listen to you and the Administration's thrust because the House approved a bill designed to move even more families off welfare into work and self-sufficiency. The difficulty, in part, is coordinating with the Senate and getting legislation that would reach the President's desk.

Prior to hearing from you, Secretary, I would ordinarily call on the gentleman from New York, but as Chairman, I would like to exercise the right—and obviously my colleague, Mr. Rangel will, and someone here on the dais wearing a similar red outfit will as well. Normally it would be of some concern with this many ladies in the audience all wearing the same red, but I think that is a badge not only of courage but honor today.

We have with us Delta Sigma Theta. The gentleman from New York would also like to recognize you, and perhaps in his presentation he can allow the gentlewoman from Ohio to have a word rather than wait her normal turn. The gentleman from New York.

[The opening statement of Chairman Thomas follows:]

Opening Statement of the Honorable Bill Thomas, Chairman, and a Representative in Congress from the State of California

Good afternoon. As we continue to explore the President's Fiscal Year 2005 budget, I'd like to welcome Health and Human Services Secretary Tommy Thompson. I look forward to your remarks on the Administration's health care and welfare reform priorities.

Last year we successfully accomplished a long standing health care goal: Providing prescription drugs to seniors under Medicare. Starting in June of this year, a prescription drug discount card will be available to seniors to help reduce their out-of-pocket costs. In just three months, over 100 companies have signaled to HHS their intent to offer discount cards to seniors. Further, we're already seeing the positive effects of other Medicare improvements in the new law. The revised reimbursement rates for integrated Medicare Advantage plans have resulted in lower premiums, improved prescription drug coverage and better health care choices for seniors. Ninety-three percent of seniors in these plans will see reduced premiums, 81 percent will have reduced copayments and deductibles and 60 percent will receive additional benefits, including prescription drugs. In addition, plans are moving into new areas, providing additional choices for seniors.

Even with the passage of the landmark Medicare law, there is still more to be done on the health care front. For too many Americans, health insurance is an unaffordable luxury, leaving them and their families vulnerable to exorbitant medical expenses. In his State of the Union address, the President outlined key initiatives aimed at making health insurance more accessible and affordable. We look forward to exploring these proposals with you in further detail.

Mr. Secretary, we also are aware of your strong leadership in welfare reform, both as governor of Wisconsin and as Secretary of HHS. No one disputes the success of welfare reform. Today, nine million fewer parents and children are dependent on welfare than before we passed the 1996 reforms. Over two million children have

been removed from poverty. And three times as many welfare recipients are working now.

Last February, the House approved a bill designed to move even more families off welfare and into work and self-sufficiency. That's the only solution to poverty, and our bill would provide more funding for child care to support that goal. But instead of improvements, we've been forced to mark time with a steady series of short-term extensions. The most recent extension expires at the end of March. It is my hope that the Senate will pass welfare reform legislation soon, so we can continue to improve the nation's welfare program.

And now, prior to hearing from you, Mr. Secretary, I would ask the gentleman from New York, Mr. Rangel, if he has any comments.

Mr. RANGEL. Thank you, Mr. Chairman. I think the Deltas represent what is good in America. They could just organize for social events, but rather than do that, they do good work not only in the community but working with the city, State, and Federal Government, and they have spent today visiting Members of Congress with long agendas, legislative agendas of things that they are concerned about.

During this time of economic and national crisis, it would appear to me that people should not be just despondent with their government but should participate and should make certain that everyone is registered, everyone is voting, everyone is doing something. The Deltas just make me so proud, because it is hard to go into any community in these great United States that we don't see evidence of their good work. I would just like to thank them for all that they do, and yield to the gentlelady from Ohio who exemplifies the best of Delta.

Ms. TUBBS JONES. Thank you, Mr. Ranking Member, Charles Rangel. Mr. Chairman, Mr. Thomas, thank you for this opportunity.

Today is Delta's Day at the Nation's Capitol. We have more than 700 women in red here, talking to their legislators both on the House and Senate side. To all of my colleagues from across this country, if you have not had a chance to get to meet members of our sorority in your congressional district, I encourage you to do so. We are both Democrat and Republican. We are here about issues that are of particular concern to our communities, and health care is one of those big concerns.

Secretary Thompson, a lot of them came because they heard that you were going to be here this afternoon, to have an opportunity. I just thank my colleagues for yielding the time and allowing me to speak out of order. This is my great sorority, Delta Sigma Theta. It is a national public service sorority, and, in fact, we were just named as a nongovernmental organization to the United Nations, one of the first sororities to have that opportunity.

So, thank you, Mr. Ranking Member. Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Secretary, welcome. These are difficult times. We have deficits that our imagination has never been able to keep up with. We hope during your presentation you might share with us how the budget was off by some $132 billion, $134 billion, where the President of the United States claimed that he did not even know what the full and precise cost estimates would be. We also are concerned, as I spoke with you earlier, about this media budget for a bill that actually takes place in 2006.

We understand that over $22 million is being spent to mail full-color brochures and buy television (TV) network time. We also are concerned with the fact that the media company that is hired for this appears to be involved in other political activities. With the cost of health care going up and the budgets going down in certain areas, we are concerned with this, these type of expenditures.

As relates to issues that are more specific, I am going to ask, with the Chairman's permission, for the Ranking Member of the Subcommittee on Health to share this time with me.

Mr. STARK. Thank you. Thank you, Mr. Chairman and Ranking Member. Welcome, Governor. Now, I won't go on about fish tales, because sometimes when the Governor is good enough to provide one of Wisconsin's delights to me as just a gift of friendship, then we find out—and he was quite up front about admitting that these walleye pike came from Canada—and perhaps he will tell us more about how the budget figures grew.

In regard to the campaign, advertising campaign, Secretary, the fact is that Medicare beneficiaries cannot under the new law keep their same Medicare. The law increases the Part B deductible to $110. It is seniors with incomes of over $80,000, will have to pay higher Part B premiums.

If the senior has a Medigap policy that covers prescription drugs, they are going to have to switch policies to assure that they can participate in the drug benefit. In many States, they will pay more for their drugs than they do under current law, and they may see their coverage reduced. We think that perhaps as many as 3 million retirees will see their employers drop their better retiree drug benefits, and millions of beneficiaries will be subject to a privatization program down the road.

When I last checked, they weren't allowed to opt out of the experiments that are in the bill. So, it is not right to tell seniors that their Medicare will remain unchanged. In fact, it is changing quite a bit, and in many instances will cost more than they are paying today. It is one of the reasons that I have asked the U.S. General Accounting Office (GAO) to review the ads and determine if they are really an appropriate use of taxpayers' funds.

The Advantage program, which lauds the billions of additional funds to managed care plans—in fact, will cost us $46 billion over the next 10 years—is really just extra money to the managed care industry, those very plans that caused us the problems under Medicare+Choice.

I guess one of the most disturbing things in your testimony, and perhaps it has been revised, is that nowhere in your testimony is there any discussion about what the Administration plans to do to help the uninsured. The President didn't mention it in his State of the Union Address, and we have got 42 million uninsured Americans.

There has been no effort on the part of the Administration to control health costs for those of us like Members of Congress who are lucky enough to have insurance. So, I guess if you don't mention the uninsured, it is because the President doesn't think that we need anything more than tax credits. I hope you can discuss some of those issues with us.

I would rather hope that you are aware that the typical family in this country, in a reasonably priced group marketplace, would have to pay about $9,100 a year for a group policy, if they could get it. Yet the President is proposing a tax credit capped at $3,000 for a family earning $25,000 a year. Where are they going to come up with at least $6,100 more than that escapes me.

My final comment is this. For us, as politicians—and I would say this in a bipartisan sense—the record of Presidents and Members of Congress as being representatives of strong marriages is pretty shabby. Why we should be spending a billion dollars or more to promote marriage when we can't define it—we are going to have a fight over who should be married and who shouldn't be married just in the politics that are going on. It seems to me that a billion dollars could be better spent on allowing mental health to have equal stature in health insurance, and that getting professional treatment might be a better way to help families stay together and grow together than going out into finding some new experts in teaching people how to be married.

I would say the same thing goes for $130 million for abstinence programs, which I find difficult to discuss in all seriousness, but I think these are foolish and folly. This is money, hundreds—over—billions of dollars that we could better spend on children and people who need the help.

So, I hope that these initiatives might be sidetracked, and we might spend whatever money is there in a way that would better promote the health of Americans. I look forward to your testimony and the questions. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Prior to recognizing the Secretary, the Chair would like to place in the record a letter from the Congressional Budget Office (CBO) that was sent to myself, and a carbon to Mr. Rangel; also to the Chairman of the Committee on Energy and Commerce; and Senators Nickles, Grassley, and the Chairman of the Budget Committee, Mr. Nussle, which I am sure, with carbons to their Ranking Members.

It is from Douglas Holtz-Eakin, outlining CBO's position on the numbers. The pertinent sentence: "therefore, CBO believes its estimate is sound and has no reason, at present, to revise it."

I am sure the Secretary will discuss it with some supporting documentation. Without objection.

[The information follows:]

Congressional Budget Office
Washington, DC 20515
February 2, 2004

Honorable William "Bill" M. Thomas
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman,

CBO's baseline budgetary projections released in the *Budget and Economic Outlook* include $395 billion in outlays over 2004 to 2013 for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173). That amount is identical to CBO's scoring of the bill when passed. In contrast, the Ad-

ministration estimates that additional outlays resulting from that act will total $534 billion over the 2004–2013 period.

Of course, a complete comparison of the overall, budgetary impact of the legislation must also consider the effect on revenues. CBO estimates that the revenue effects of the legislation are largely offsetting. The legislation reduces revenues by providing qualified taxpayers with health savings accounts. At the same time, it increases revenues, CBO estimates, as businesses reduce expenditures on nontaxable health benefits and increase them on taxable wages. The Administration has not released its estimated effects of the legislation on revenues. Those estimates could certainly differ from CBO's.

Because the new prescription drug program represents a major departure from what currently exists, there is a great deal of uncertainty about its budgetary impact and a wide range of possible outcomes. CBO's estimate was the result of extensive analyses of the pharmaceutical drug market, the Medicare program, and the likely responses of potential enrollees. To date, we have not received any additional data or studies that would lead us to reconsider our conclusions. *Therefore, CBO believes its estimate is sound, and has no reason, at present, to revise it.*

CBO has consulted with the Administration to identify the major factors that account for the differences between the two estimates. Although such a comparison is complicated and we do not have complete detail on the key attributes, it appears that the difference derives from of differing assumptions or estimates in a number of areas. Attached is a summary of those major differences. We will continue to work with the Administration to understand the differences in more detail.

I hope this information is helpful to you. The CBO staff, contact for this analysis is Tom Bradley, who can be reached at 226–9010.

Sincerely,

Douglas Holtz-Eakin
Director

Enclosure

cc: Honorable Charles B. Rangel, Ranking Member

Identical letters sent to Honorable W.J. "Billy" Tauzin, Honorable Don Nickles, Honorable Charles E. Grassley, and Honorable Jim Nussle

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In addition to that, so that we know what we are talking about, I want to include this 2-page multicolor flyer which is the Centers for Medicare & Medicaid Services (CMS) explanation of the new program. Without objection, we would put that in the record.

[The information follows:]

The Facts about Upcoming New Benefits in Medicare

Medicare Prescription Drug Improvement and Modernization Act of 2003

MEDICARE is an essential health care program for people age 65 and older and people with disabilities.

Recently, President Bush and Congress worked together to pass a new law to bring people with Medicare more choices in health care coverage and better health care benefits.

This new law preserves and strengthens the current Medicare program, adds important new prescription drug and preventive benefits, and provides extra help to people with low incomes. You will still be able to choose doctors, hospitals and pharmacies.

If you are happy with the Medicare coverage you have, you can keep it exactly the same. Or, you can choose to enroll in new options described below. No matter what you decide, you are still in the Medicare program.

Drug Discount Cards Start in 2004

Medicare-Approved Drug Discount Cards will be available in 2004 to help you save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval can help you save 10-25% on prescription drugs.

You can enroll beginning as early as May 2004 and continuing through December 31, 2005. Enrolling is your choice. Medicare will send you information soon with details about how to enroll.

People in the greatest need will have the greatest help available to them. If your income in 2003 is less than $12,124 for a single person or less than $16,363 for a married couple, you might qualify for a $600 credit on your discount card to help pay for your prescription drugs. (You can't qualify for the $600 if you already have drug coverage from Medicaid, TRICARE for Life or an employer group health plan.)

Also new in 2004, Medicare Advantage is the new name for Medicare+Choice plans. Medicare Advantage rules and payments are improved to give you more health plan choices and better benefits. Plan choices might have improved already in your area. To find out more, call 1-800-MEDICARE (1-800-633-4227).

New and Improved Preventive Benefits Start in 2005

New Preventive Benefits will be covered, including:

- One-time initial wellness physical exam within 6 months of the day you first enroll in Medicare Part B.
- Screening blood tests for early detection of cardiovascular (heart) diseases.
- Diabetes screening tests for people with Medicare at risk of getting diabetes.

These benefits add to the many preventive services that Medicare already covers, such as cancer screenings, bone mass measurements and vaccinations.

Prescription Drug Plans Start in 2006

Prescription Drug Benefits will be added to Medicare in 2006. All people with Medicare will be able to enroll in plans that cover prescription drugs. Plans might vary, but in general, this is how they will work:

- You will choose a prescription drug plan and pay a premium of about $35 a month.
- You will pay the first $250 (called a "deductible").
- Medicare then will pay 75% of costs between $250 and $2,250 in drug spending. You will pay only 25% of these costs.
- You will pay 100% of the drug costs above $2,250 until you reach $3,600 in out-of-pocket spending.
- Medicare will pay about 95% of the costs after you have spent $3,600.

Some prescription drug plans may have additional options to help you pay the out-of pocket costs.

Extra Help Will be Available for people with low incomes and limited assets. Most significantly, people with Medicare in the greatest need, who have incomes below a certain limit won't have to pay the premiums or deductible for prescription drugs. The income limits will be set in 2005. If you qualify, you will only pay a small co-payment for each prescription you need.

Other people with low incomes and limited assets will get help paying the premiums and deductible. The amount they pay for each prescription will be limited.

Medicare Advantage plan choices will be expanded to include regional preferred provider organization plans (PPOs). Regional PPOs will help ensure that all people with Medicare have multiple choices for Medicare health coverage, no matter where they live. PPOs can help you save money by choosing from doctors and providers on a plan's "preferred" list, but usually don't require you to get a referral. PPOs are among the most common and popular plans right now for working Americans.

All of these options are voluntary. You can choose to remain in the traditional Medicare plan you have today.

News for All Americans

Starting immediately, Americans will be able to set aside money each year, tax free, in Health Savings Accounts. The savings accounts can be used to pay for medical expenses, and money not spent would stay in the account and gain interest tax-free, just like an Individual Retirement Account (IRA). Your health insurance deductible must be at least $1,000 for a single person and at least $2,000 for family coverage.

Questions about Medicare?

For the latest information about Medicare, visit www.medicare.gov or call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

To get a copy of this information in Spanish, call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048. Para una copia en español, llame gratis al **1-800-MEDICARE** (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

CMS

To allow for some understanding and comparison, I would also like to put in the record a 1996 HHS handbook from the previous Administration. Heavy cover. Completely blank picture on this side. A picture of the Secretary, a picture of the administrator, with a brief greeting, 30 pages of gray material printed out, and with a bulk-rate stamp on the back, mailed to every senior. Of course, I appreciate our colleagues on the other side of the aisle's concern at the time this was mailed to seniors, when in fact, not one page in here discusses a prescription drug program for seniors, as this 2-page document discusses as early as this June in terms of a discount card. Without objection, the Chair would place that in the record.

[The information is being retained in the Committee files.]

Secretary, nice to have you with us again. Your written testimony will be made a part of the record, and you may address us in any way you see fit.

STATEMENT OF THE HONORABLE TOMMY G. THOMPSON, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. THOMPSON. Thank you very much, Mr. Chairman. First let me thank you for giving me this opportunity to testify, and the same for you, Congressman Rangel. I also would like to join with Congresswoman Tubbs Jones in welcoming the wonderful sorority Delta to the Capitol today, and hope that they will listen to some of the questions and get some of the answers that they are hoping for as far as health care is concerned.

I also want to thank all Members of this Committee for allowing me this opportunity to discuss the President's fiscal year 2005 budget for HHS.

In my first 3 years at the Department, we have made, I believe, tremendous progress in improving the health, the safety, and the independence of the American people. We continue to advance in providing health care to seniors and to lower-income Americans, in improving the well-being of children and strengthening families, and in protecting the homeland.

We are building a new public health infrastructure in order to give doctors and hospitals the tools they need to respond to any public health emergency. We have reenergized the fight against Acquired Immune Deficiency Syndrome (AIDS) at home and abroad. We increased access to quality health care, especially for minorities, the uninsured, and the underinsured. With your help, 2 months ago President Bush signed the most comprehensive improvements to Medicare since it was created nearly four decades ago.

To expand on our achievements, the President proposes $580 billion for HHS for fiscal year 2005, an increase of $32 billion, or 6 percent, over fiscal year 2004.

Our discretionary budget authority is $67 billion, an increase of $819 million, or 1.2-percent increase over fiscal year 2004 and an increase of 26 percent since 2001.

President Bush seeks to build on the success of the 1996 Welfare Reform (P.L. 104–193) law by reauthorizing the successful Temporary Assistance for Needy Families (TANF) program to help

more welfare recipients achieve independence through work and protect children and strengthen families. I appreciate this body's approval of TANF reauthorization last year, and I look forward to working with all of you to shepherd this bill through the Senate this year. We can and we should accomplish this critical goal this year.

We are also working to protect our most vulnerable children. The Federal Government will spend nearly $5 billion this year for foster care. We would fund existing adoption bonuses as well as the new bonuses that Congress approved last year with $35 million for 2004 and $32 million for 2005.

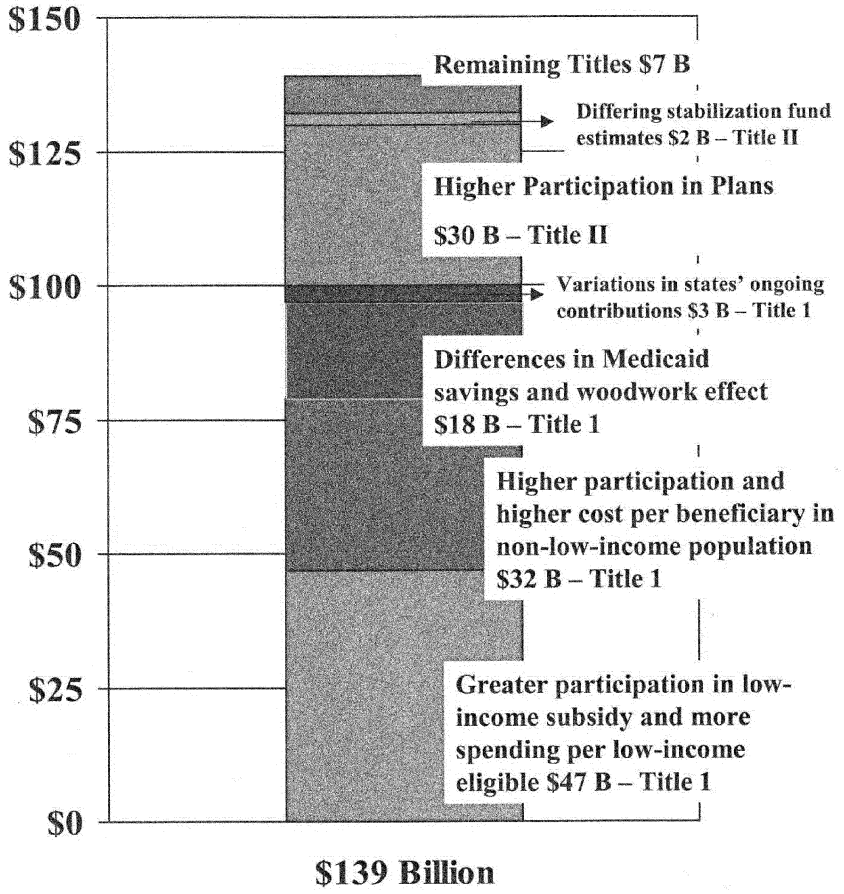
To support our commitment to helping families in crisis and to protecting children from abuse and neglect, President Bush has requested full funding, $505 million for the promotion of the Safe and Stable Families program. Of course, the new Medicare Modernization Act is a significant accomplishment for our Department.

Adding these benefits and choices and educating seniors about them will become a significant challenge. You and your fellow lawmakers were right to follow the CBO's score in making decisions. When CBO scores the budget we submitted last week, it would be expected, as was introduced by the Chairman, that the estimate would reflect the $395 billion of that particular amount.

I would like to direct your attention to the chart. There is a lot of discussion about the differences between CBO and the Office of the Actuary estimates of the Medicare Modernization Act.

[The chart follows:]

Differences Between CBO and Office of the Actuary Estimates of MMA



The bottom blue strip consists of $47 billion. Now, this is the difference between participation. The CBO does not believe as many of the low-income seniors are going to participate as much as the CMS Actuary does. That difference is $47 billion.

Now, I have asked our actuaries to sit down with CBO and be able to try and explain those differences when they come in front of this Committee, I believe at a later date, to discuss that.

The second one is $32 billion. This—all the four blue are for Title 1. That is your drug portion of Medicare. The $32 billion is the difference between CBO and our actuaries, and is based upon who is going to participate. You have a universe of 100 percent. Our actuaries subtract 5 percent from that figure for those individuals that will remain with their employer's coverage. That gets it down to 95

percent. They believe that only 94 percent of the 95 percent will participate in Title 1, the drug card.

The CBO, on the other side, does not believe that. Under Part B, only 91 percent of the people participate in Part B. The CBO says that if you don't participate in Part B, it is very doubtful that you will participate in Part D as well. Therefore, they subtracted out the 9 percent, and they reduced the balance down to 91 percent, and then they said only 87 percent of those will continue to participate. That difference between 87 percent and 94 percent of who will participate is a difference of $32 billion.

Then the difference in Medicaid savings. The CBO does not believe that there were any States that had prescription drug coverage that was budget neutral. They believe that when Part D comes into play, that they will take that over and they will drop their State programs, making a savings. Our actuaries believe that there were savings built in when we granted the waivers for those States to set up the program. Therefore, there will not be any savings.

Also there is a difference as to "woodwork effect." When people find out about Part D, there are going to be more people applying for it. Therefore, they are going to find out that they may also be eligible for Medicaid. That is the difference of the $18 billion.

Then the final one under blue is $3 billion. We believe that CBO is estimating an additional $3 billion more that the States will be paying in when they participate in the Medicaid program.

The second one is Title 2. This is where the plans come into play, and there is a difference of $30 billion there. We believe that—CBO believes that only 14 percent of the people will participate in the plans. Right now it is 11.8 percent. They believe it is only going to go up to 14 percent. Our actuaries believe it will be one-third. That is the difference between $30 billion.

Then there is a stabilization fund of $2 billion that CBO does not believe we will ever use, and our actuaries believe that it will. That is the difference.

Then the remaining 10 Titles of the new Medicare bill have a difference of $7 billion. That is the difference of $139 billion between CBO and our actuaries.

Now, finally, I don't have enough time to get into the new benefit proposals, but it appears that more than half of the current enrollees will see better benefits and that almost half of the current enrollees will see reduced premiums or cost sharing.

The bottom line is that extra payments are providing more to beneficiaries, just as was intended by the Medicare Modernization Act. We look forward to working with Congress, the medical community, and all Americans as we implement the new Medicare law and carry out the initiatives that President Bush is proposing to build a healthier, safer, and stronger America.

I don't have time to go into the uninsured or the advertising program, but I am sure there will be questions about that, and I would be more than happy to answer them when they come up. Thank you for giving me this opportunity to give you the explanation on the difference of the figures.

[The prepared statement of Mr. Thompson follows:]

Statement of the Honorable Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services

Good morning, Mr. Chairman and members of the Committee. I am pleased to present to you the President's FY 2005 budget for the Department of Health and Human Services (HHS). I am confident you will find our budget to be an equitable proposal to improve the health and well-being of our Nation's citizens.

This year's budget proposal builds upon HHS accomplishments in meeting several of the health and safety goals established at the beginning of the current Administration. This year, Congress passed the comprehensive Medicare reform legislation, adding prescription drug coverage for seniors and modernizing the Medicare program.

- Since 2001, with the support Congress, the Administration has funded 614 new and expanded health centers that target low-income individuals, effectively increasing access to health care for an additional three (3) million people, a 29 percent increase.
- The Department established the Access to Recovery State Vouchers program, providing 50,000 individuals with needed treatment and recovery services.
- To support the President's faith-based initiative, HHS has created the Compassion Capital Fund for public/private partnerships to support charitable groups in expanding model social services programs. We awarded 81 new and continuing grants in 2003.
- HHS initiated a new Mentoring Children of Prisoners program to provide one-to-one mentoring for over 30,000 children with an incarcerated parent in FY 2004. The Department also created education and training vouchers for foster care youth, providing $5,000 vouchers to 17,400 eligible youth.
- In August 2001, the President and I invited States to participate in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. States use HIFA demonstrations to expand health care coverage. As of January 2004, HIFA demonstrations had expanded coverage to 175,000 people, and another 646,000 were approved for enrollment.

I could go on listing our achievements to you and the Committee, Mr. Chairman, but instead I have chosen to highlight a few that we are most proud of.

For FY 2005, the President proposes an HHS budget of $580 billion in outlays to enable the Department to continue working with our State and local government partners, as well as with the private and volunteer sectors, to ensure the health, well-being, and safety of our Nation. Through the programs and services presented in the budget plan of HHS, Americans will receive new health benefits and services, be better protected from the threat of bioterrorism, benefit from enhanced disease detection and prevention, have greater access to health care, and will see improved social services through the work of faith- and community-based organizations and a focus on healthy family development. This proposal is a $32 billion in outlays increase over the comparable FY 2004 budget, or an increase of about 5.9 percent. The discretionary request for the HHS budget totals $67 billion in budget authority, a 1.2 percent increase.

Your committee, Mr. Chairman, has jurisdiction over much of this budget. I am grateful for the hard work and achievements we have made together. Allow me to draw your attention to several key factors of the HHS budget so that we may continue to work together to address the needs of our Nation.

Medicare and Medicaid Reform/Modernization

I am proud to remind the Committee of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which President Bush signed into law December 8, 2003. With the implementation of MMA, the Department faces many challenges in the coming fiscal year. As the most significant reform of Medicare since its inception in 1965, the law expands health plan choices for beneficiaries and adds a prescription drug benefit. MMA will strengthen and improve the Medicare program, while providing beneficiaries with new benefits and the option of retaining their traditional coverage. The HHS FY 2005 budget request includes about $482 billion in net outlays to finance Medicare, Medicaid, the State's Children's Health Insurance Program, the Health Care Fraud and Abuse Control Program, state insurance enforcement, and the Agency's operating costs.

Drug Discount Card

MMA establishes a new, exciting Medicare approved prescription drug discount card program, providing immediate relief to those beneficiaries who have been burdened by their drug costs. From June 2004 through 2005, all Medicare beneficiaries, except those with Medicaid drug coverage, will have the choice of enrolling in a

Medicare-endorsed drug discount card program. With the discount card, beneficiaries will save an estimated 10 to 15 percent on their drug costs. For some, savings may reach up to 25 percent on individual prescriptions. A typical senior with $1,285 in yearly drug expenses could save as much as $300 annually. To enroll, beneficiaries will pay no more than $30 annually. Those with low incomes will qualify for a $600 per year subsidy to purchase drugs. Medicare also will cover the enrollment fees for low-income seniors.

Voluntary Prescription Drug Benefit

Responding to President Bush's pledge to add meaningful drug coverage to Medicare, MMA establishes a new voluntary prescription drug benefit under a new Medicare Part D. Starting in 2006, Medicare beneficiaries who are entitled to Part A, or enrolled in Part B, can choose prescription drug coverage under the new Part D. Under Part D, beneficiaries can choose to enroll in stand-alone, prescription drug plans (PDPs) or Medicare Advantage prescription drug plans (MA–PDs), and will be able to choose between at least two plans to receive their benefit. The law contains important beneficiary protections. For example, while the plans are permitted to use formularies, they must include drugs within each therapeutic category and class of covered Part D drugs, allowing beneficiaries to have a choice of drugs. In instances in which a drug is not covered, beneficiaries can appeal to have the drug included in the formulary. To reduce the number of prescribing errors that occur each year, HHS will develop an electronic prescription program for Part D covered drugs.

Medicare Advantage

MMA replaces the Medicare+Choice program with a new program called Medicare Advantage, which will operate under Part C of Medicare. Starting in 2004, the new law changes how private plans operating under Part C will be paid. In response to the increasing costs of caring for Medicare beneficiaries, the law increases payments to managed care plans by $14.2 billion over 10 years. These enhanced payments will allow private plans to provide more generous coverage, including benefits that traditional Medicare may not offer. Specifically in 2004, plans must use these funds to provide additional benefits, to lower premiums and/or cost-sharing, or to improve provider access in their network. This increased compensation will also encourage more private plans to enter the Medicare market, improving beneficiaries' overall access to care.

Under Medicare Advantage, local managed care plans will continue to operate on a county-by-county basis. Beginning in 2006, Medicare Advantage also will offer regional plans, which will cover both in-network and out-of-network services in a model very similar to what we in the Federal Government enjoy through the Federal Employee Health Benefits Program. There will be at least 10 regions, but no more than 50. The regional plans must use a unified deductible and offer catastrophic protection, such as capping out-of-pocket expenses.

The changes in the Medicare Advantage program will provide seniors with more choices, improved benefits, and provide beneficiaries a choice for integrated care—combining medical and prescription drug coverage. We project that 32 percent of Medicare beneficiaries will enroll in Medicare Advantage plans by 2010.

Providers and Rural Health

Recognizing geographic disparities in Medicare payments, MMA provides much needed relief to rural providers by equalizing the standardized amounts paid to both urban and rural hospitals. Along with standardizing the base payment amounts to both urban and rural hospitals, MMA reduces the labor share of the standardized payment amount. In addition, Mr. Chairman, MMA increases payments for Disproportionate Share Hospitals (DSH) and provides greater flexibility to Graduate Medical Education (GME) residencies. The new law also increases flexibility for hospitals seeking Sole Community Hospital (SCH) status and eases the requirements for achieving Critical Access Hospital (CAH) status. Critical Access Hospitals will receive increased payments under MMA, as the payment rate will be increased to 101 percent of allowable costs.

Providers will see increased reimbursements under MMA. Physicians practicing in defined shortage areas will receive an additional 5 percent payment bonus. Home Health Agencies in rural areas also will receive a 5 percent bonus. In a change for rural hospice providers, more freedom will be given to utilize nurse practitioners. The law also creates an Office of Rural Health Policy Improvements and requires demonstration projects involving telehealth, frontier services, rural hospitals, and safe harbors.

Preventive Benefits

MMA expands the number of preventive benefits covered by Medicare beginning in 2005. Through a particularly important provision, an initial preventive physical examination will be offered within six months of enrollment for those beneficiaries whose Medicare Part B coverage begins January 1, 2005 or later. The examination, as appropriate, will include an electrocardiogram and education, counseling, and referral for screenings and preventive services already covered by Medicare, such as pneumococcal, influenza and hepatitis B vaccines; prostate, colorectal, breast, and cervical cancers; in addition to screening for glaucoma and diabetes. Diabetes and cardiovascular screening blood tests do not have any deductible or co-payments, as Medicare pays for 100 percent of these clinical laboratory tests.

Regulatory Reform/Contracting Reform

MMA includes a number of administrative and operational reforms, as well. For example, regulatory reform provisions require the establishment of overpayment recovery plans in case of hardship; prohibit contractors from using extrapolation to determine overpayment amounts except under specific circumstances; describe the rights of providers when under audit by Medicare contractors; require the establishment of standard methodology to use when selecting a probe sample of claims for review; and prohibit a supplier or provider from paying a penalty resulting from adherence to guidelines. In addition, MMA allows physicians to reassign payment for Medicare services to entities with which the physicians have an independent contractor arrangement. Under the new law, final regulations are to be published within three years, and all measures of a regulation are to be published as a proposed rule before final publication.

Also under the law, as Secretary, I will be permitted to introduce greater competitiveness and flexibility to the Medicare contracting process by removing the distinction between Part A and Part B contractors, allowing the renewal of contracts annually for up to five years, limiting contractor liability, and providing incentive payments to improve contractor performance. These changes will enhance HHS efficiency and effectiveness in program operations.

Regarding Medicare appeals, MMA changes the process for fee-for-service Medicare by requiring the Social Security Administration and HHS to develop and implement a plan for shifting the appeals function from SSA to HHS by October 1, 2005. MMA also changes the requirements for the presentation of evidence. This also will enhance the efficiency and effectiveness of the operation of the Medicare program.

Medicare and Medicaid Estimates

Historically, HHS and the Congressional Budget Office (CBO) have provided differing estimates of Medicare and Medicaid spending. It is not uncommon for different assumptions underlying the respective estimates to produce differences in cost projections. This year's new estimates include the changes resulting from enactment of MMA.

When Congress considered this Act, Mr. Chairman, CBO estimated the cost of the bill at $395 billion from 2004 to 2013. The HHS actuaries have recently estimated the cost of the law as $534 billion from 2004 to 2013. Last week, the CBO Director told the House and Senate Budget Committees that CBO has not changed its estimate and that they continue to believe that the cost of the bill is $395 billion. Because the Medicare legislation makes far-reaching changes to a complex entitlement program with many new private-sector elements, there is even larger uncertainty in these estimates than usual.

The two sets of estimates provide a reasonable range of possible future cost scenarios for Medicare spending. The tremendous uncertainty surrounding estimates of the newly-enacted Medicare law has resulted in a plausible range of estimates of future cost scenarios for Medicare spending, from the $395 billion estimate from CBO to the $534 billion estimate from the Medicare actuaries. It should be noted that this difference of $139 billion is approximately two (2) percent of the projected $7 trillion in total Federal Medicare and Medicaid spending over the same period, as projected by HHS.

Additional MMA Changes

We are currently reviewing the new benefit proposals submitted by health plans and will have detailed information very soon on how this extra funding is helping Medicare beneficiaries. In general it looks like over half of current enrollees will see better benefits, and nearly one-half will see reduced premiums or cost sharing. When looking at the average premium paid by enrollees across all plans, this premium may be decreasing by as much as one-third. The bottom line is that the extra payments are working as required by the MMA—to provide more to beneficiaries.

MMA addresses other issues facing the Medicare program including the program's long-term, financial security. To contain costs in the Medicare program, the law requires the Medicare Trustees, beginning in the 2005 annual report, to assess whether Medicare's "excess general revenue funding" exceeds 45 percent. As defined in the law, excess general revenue funding is equal to Medicare's total outlays minus dedicated revenues. The Medicare Trustees shall issue a "warning" if general revenues are projected to exceed 45 percent of Medicare spending in a year within the next seven years. If the Trustees issue such a warning in two consecutive years, the law provides special legislative conditions for the consideration of proposed legislation submitted by the President to address the excess general revenue funding.

Marriage and Healthy Family Development

This year, Mr. Chairman, the President is proposing a new marriage and healthy family development initiative. This Initiative is supported by funding increases in this Department's FY 2005 budget, encompasses a variety of new and existing programs, and impacts both mandatory and discretionary programs.

Building on the considerable success of welfare reform in this great Nation, the President's FY 2005 Budget maintains the framework of the Administration's welfare authorization proposal. Mr. Chairman, we are committed to working with the Congress in the coming months to ensure the legislation moves quickly and is consistent with the President's Budget. The President's proposal includes five years of funding for the TANF Block Grant to States and Tribes; Matching Grants to Territories; and Tribal Work Program. A new feature, intended to support the President's Marriage and Healthy Family Development Initiative, is a proposal for increased funding for two key provisions in our welfare reform package.

A cornerstone of the President's commitment to strengthen and empower America's families through welfare reform provides targeted resources to family formation and healthy marriage strategies. Statistics tell us that children from married two parent families are less likely to end up in poverty, drop out of school, become addicted to drugs, have a child out of wedlock, suffer abuse or become a violent criminal and end up in prison. While government cannot create good marriages, it can play a role by providing resources and expertise so that individuals and couples are better prepared to form and maintain happy and healthy families.

Beginning in FY 2005, the FY 2005 budget would provide an additional $20 million, a total of $120 million, under TANF to support research, demonstrations, and technical assistance primarily focused on family formation strategies and healthy marriages and an additional $20 million for matching grants to States, Territories, Tribes, and Tribal Organizations for innovative approaches to promoting healthy marriage and reducing out-of-wedlock births. A dollar-for-dollar match to participate in the grant program will be required, generating another $20 million in matching State and local funds. States can use Federal TANF funds to meet this matching requirement. In total, $360 million in Federal and State funding would be available in the FY 2005 Budget to broaden the Administration's efforts to support healthy marriages and promote effective family formation.

To reverse the rise in father absence and improve the well-being of our Nation's children, the budget includes a total of $50 million for grants for public entities; nonprofits, including faith-based; and community organizations to design demonstration service projects. These projects will test promising approaches to improve outcomes for children by encouraging the formation and stability of healthy marriages and responsible fatherhood, and to assist fathers in being more actively involved in the lives of their children.

President Bush also announced in his State of the Union address a new initiative to educate teens and parents about the health risks associated with premarital sexual activity and to provide the tools needed to help teens make responsible choices. To do this, the President proposes to double funding for abstinence education activities for a total of $273 million, including a request of $186 million, an increase of $112 million, for grants to develop and implement abstinence educations programs for adolescents aged 12 through 18 in communities across the country; the reauthorization of state abstinence education grants for five years at $50 million per year as part of the welfare reform reauthorization; another $26 million for abstinence activities within the Adolescent Family Life program; and a new public awareness campaign to help parents communicate with their children about the health risks associated with premarital sexual activity.

In addition, the budget provides for significant increases to two state child abuse programs reauthorized this past year as part of the Keeping Children and Families Safe Act of 2003. The increase for the Child Abuse Prevention and Treatment State Grants will enable state child protective service systems to shorten the time to the delivery of post-investigative services from 48 to 30 days. The Community-Based

Child Abuse Prevention program will increase the availability of prevention services to an additional 55,000 children and their families.

Child Welfare

One of my highest priorities this year is to address the needs of some of this Nation's most vulnerable children. The Federal government will spend nearly $5 billion for Foster Care this year. However, the program's current structure does not allow States to do all they can to prevent a child's removal from the home, reunify families when possible, and, when necessary, find an alternative safe and nurturing family environment. The current financing structure sends the wrong message by providing the bulk of funding only when children are removed from their homes.

Our budget includes an option for States to receive their funds in an allotment, providing States more flexibility in the operation of their child welfare programs. The option gives States the opportunity to craft their program to meet the specific needs of their unique populations. The funds can still be used for foster care when needed, but also for prevention and other critical services. Furthermore, the HHS budget reflects savings associated with a legislative proposal to clarify the definition of "home of removal" in the foster care program in response to a court decision. The President's FY 2005 budget also proposes $140 million for the Independent Living Program and $60 million for the Independent Living Education and Training Vouchers program. Additionally, to support the Administration's commitment to helping families in crisis and to protecting children from abuse and neglect, the President's FY 2005 budget requests $505 million, full funding, of the Promoting Safe and Stable Families program. I know we all agree that the safety of our Nation's children is paramount and I look forward to working with Congress to rework the foster care program.

Child Support Enforcement

In my first two years at the Department, the Child Support Enforcement program collected and distributed $39 billion in child support. With the preliminary FY 2003 collections figure, the three year total is an impressive $60 billion. This highly effective program provided $4.13 in child support collections for every Federal dollar invested in FY 2002.

The President's FY 2005 budget builds on the program's success by arming the States with additional powerful tools to get the essential support that children need. Our newest proposals focus on critical improvements to collect medical child support. The first proposal notifies child support agencies if a child with a medical support order loses health care coverage (COBRA notices) so child support professionals can assist that family in providing continuous health care coverage. Another improvement will give States the authority to consider both parents' access to health care coverage when establishing medical child support orders, with the option of enforcing these orders against both custodial and non-custodial parents. These improvements will help prevent lapses in children's health care coverage, provide more children with private health care coverage, and lead to healthier children and families.

Also included as part of the FY 2005 budget are proposals from the FY 2004 budget that provide new and improved tools to significantly increase collections to families, enhance and expand the existing automated enforcement infrastructure for Federal, State, and Tribal child support programs, and strengthen relationships between children and their absent parents. For example, one proposal increases resources for the Access and Visitation Program in support of the Administration's commitment to building strong families. These funds have been effective in facilitating visitation between non-custodial parents and their children, among other important relationship building activities. This budget also includes proposals from the FY 2003 budget aimed at increasing collections and helping families achieve independence. Two key provisions, included as part of TANF reauthorization, provide States with the option to disregard and pass through additional child support collections to families on TANF and simplify distribution rules so that families formerly on TANF can receive the funds collected on their behalf. In total, these proposals should result in an additional $3 billion to families over five years.

Compassion and Faith Based Agenda

Compassion Capital Fund

The FY 2005 budget requests $100 million for the Compassion Capital Fund, which creates public/private partnerships that support charitable organizations in expanding or emulating model social service programs. In 2003, HHS received over 1,300 applications for both the intermediary and mini-grant programs. Sixty-two

new awards were made. The President has requested a $52 million increase over FY 2004 levels to reach a greater number of qualified organizations.

Samaritan Initiative

The President's budget also continues and strengthens the Administration's commitment to end chronic homelessness by proposing $70 million for the Samaritan Initiative, a new competitive grant program jointly administered by the Departments of Housing and Urban Development, Health and Human Services, and Veterans Affairs that supports the Administration's efforts to end chronic homelessness by 2012. These grants will support the most promising local strategies to move chronically homeless persons from the streets to safe permanent housing with supportive services. Of the $70 million for the program, we are requesting $10 million at HHS for supportive services.

Domestic and Global Health Improvements

I would like to take a moment to share with the Committee a few other priorities that strengthen our efforts for a healthier U.S. Building on the accomplishment of the five-year doubling of the National Institutes of Health (NIH) budget, this year's budget proposal includes $28.6 billion for NIH. These funds will continue to support the long-term stability of the biomedical research enterprise and ensure continued productivity in all areas of research at NIH. To bring medical research and advances to those who need it, $1.8 billion of the HHS budget proposal provides health care services to 15 million individuals through the Health Center program and an increase for the National Health Service Corps to initiate recruitment of nurses and physicians.

The President's budget proposal for FY 2005 also strives to meet the needs of our vulnerable populations. To protect our children from preventable illness, the budget proposes improvements to the Vaccines for Children (VFC) program to increase access to needed vaccines for underinsured children. In an effort to ensure we have enough vaccines when they are needed, the HHS budget request calls for a six-month stockpile of all regularly recommended vaccines for children, as well as for a stockpile of influenza vaccine for next winter. In addition to our Nation's children, we must not forget those struggling yet who are ready to help themselves out of the cycle of addiction and dependency. For FY 2005, the President proposes to double the Access to Recovery State Voucher program, for a total of $200 million, to provide vouchers to approximately 100,000 individuals seeking substance abuse treatment services.

Our Nation's health, Mr. Chairman, is not dependent solely on access to care and treatment, but also on the security of our health in a global context. Our Nation faces threats from bioterrorism, disease outbreaks in other countries, and food-borne diseases and illnesses. The HHS budget targets $373 million of investments to accelerate the detection of and response to potential disease outbreaks of any kind, regardless of whether the pathogen is naturally occurring or intentionally released. The Food and Drug Administration (FDA) has already expanded its work dramatically to prevent intentionally contaminated foods from entering the U.S. The President's FY 2005 budget takes the next step by making the needed investments in FDA to expand substantially the laboratory capacity of its State partners, and to find faster and better ways to detect contamination, particularly at ports, processing plants, and other food facilities.

Management Improvements

Finally, I would like to update the Committee on the Department's efforts to use our resources in the most efficient manner. To this end, HHS remains committed to setting measurable performance goals for all HHS programs and holding managers accountable for achieving results. I am pleased to report that HHS is making steady progress. We have made strides to streamline and make performance reporting more relevant to decision makers and citizens. As a result, the Department is better able to use performance results to manage and to improve programs. By raising our standards of success, we improve our efficiency and increase our capability to improve the health of every American citizen.

Improving the Health, Safety, and Well-being of Our Nation

Mr. Chairman and members of the Committee, the budget I bring before you contains many different elements of a single proposal. The common thread running through these policies is the desire to improve the lives of the American people. Our FY 2005 HHS budget proposal builds upon our past successes to improve the Nation's health; to focus on improved health outcomes for those most in need; to promote the economic and social well-being of children, youth, families, and communities; and to protect us against biologic and other threats through preparedness at

both the domestic and global levels. It is with the single, simple goal of ensuring a safe and healthy America that I have presented the President's FY 2005 budget today. I know this is a goal we all share, and with your support, we at the Department of Health and Human Services are committed to achieving it.

Chairman THOMAS. Thank you very much, Mr. Secretary. As you well know and perhaps other people don't, Congress is required to use the CBO estimates as provided to us for our determination of the costs. The letter that I just put in the record said that CBO has no reason to change their estimates of the $395 billion.

Looking at your color chart, and of course the audience can't see this—and we might turn it around at some point so that they can see the magnitudes—the big-bucks differences are in three areas, actually four areas, and they all involve an attempt to assume people's behaviors several years from now, or close to a decade from now, as to what their decision is in either going with the program or not. The single biggest area I see is whether or not the low-income eligible are going to participate in the program.

I think all of us here hope that whoever estimated the higher percentage of participation wins the guessing contest because, frankly, there are a number of people out there who could be receiving benefits today but aren't. That would be the $47 billion.

The difference—and this is where the size of the population and the dollars become somewhat staggering. If your estimators assume a 94-percent pick-up and CBO only estimates an 87-percent pick-up, the difference between 94 and 87 percent over that 10-year period produces a $32 billion difference. That small of an estimate. So, if it is somewhere between 87 and 94 percent, if it is 88 or 89 or 90 percent, the discrepancy shrinks.

If that is the high and the low between 87 and 94 percent, it seems to me if you back away, if you are grading in school, the differences between a B-plus and an A-minus or an A-minus and an A—and for estimators over the 10 years that is maybe a 2-percent difference of the total amount, which isn't all that bad.

However, we are required by law to follow CBO. The Office of Management and Budget (OMB) has its own beliefs on what the take-up rates are. The higher participation in plans, the difference between 14 and 34 percent, would hope that CBO at 14 percent was a floor that is too low, your estimate of one-third or 34 percent take-up on the new plans is certainly optimistic. Again my assumption is it is going to be somewhere in between, which would then shrink the dollar amount if it were somewhere in between.

Then the difference in Medicaid, and as you called it the "woodwork effect," who is going to come out of the woodwork—I strongly believe that these support programs, especially those above the 100 percent of poverty, the so-called Quimbys and Slimbys, since the States were the screening structure and they had to put in 50 cents of every dollar, I have not seen a uniformly aggressive recruitment program. Some States, frankly, did better than others.

My strong belief, and I believe you shared it in your testimony, that when this is a national program—as it will be—we can, through uniform advertising and, frankly, the Federal Government's role, increase the sign-up and therefore the participation of

low-income seniors at a much higher rate. If we are able to pick up more seniors who are eligible, and it costs us $18 billion in the difference in the analysis, I would prefer your more optimistic scenario about effectively going after people who already deserve these programs and aren't taking them.

When you add those four areas up, $127 billion of the $139 billion difference is attempting to guess behavior 6 to 8 years in the future. I certainly believe people have a difference of opinion as to how the take-up rates would attain.

You come up with a figure $139 billion greater over 10 years than the CBO. We are always interested in why people are apart in terms of the assumptions that they make. When the trustee's Social Security report is presented—and I believe that is usually in early March—the Chair is going to request the actuaries from the Administration and Dr. Holtz-Eakin, the head of the CBO, to appear before us on the same panel so that we can listen to the explanations of each, and perhaps have each quiz each other as we have done in the past, so that we can better understand this rather arcane area of estimating.

It isn't a surprise to me that two groups of actuaries beginning with different assumptions about behavior wind up at different dollar amounts. The tragedy, if there is any in this, is that they both have to come up with a specific dollar amount which we know is going to be wrong. You can't guess a single number and be right. So, if you assume the bottom end was $395 billion and the top end was your $537 billion, $534 billion, somewhere in the mid-$400 or low $400 of billions would be more likely. Out of this, I hope all of us appreciate the difficulty in trying to pick a number based upon people's behavior sometime in the future. I know some people were surprised that your number was higher. I personally was not, because of the conversations that were public between the Administration and Members of Congress about what they thought the opportunities for the programs in terms of getting seniors to adopt the programs were going to be.

I think the safest statement to say is that I believe the CBO was a little pessimistic, and I believe that HHS is a little optimistic, and that the actual numbers will be somewhere in between. The point that we shouldn't lose sight of is the point somewhere in between is a better Medicare, including prescription drugs, with far better preventative and wellness programs available to seniors than ever before. Especially at the period of that 30-page very slick, very expensive 1996 Medicare brochure with the pictures of the Secretary and the Administrator, the first thing that seniors saw, rather than the announcement that prescription drugs are available for seniors under Medicare for the first time.

I look forward to more specific information from the Administration, especially in the area of health insurance. We are wrestling with a number of options; as my colleague from New York indicated, tax credits might be one approach, I believe there are other approaches, so that we can make sure that no American goes without health insurance. There is no reason why this society cannot provide it.

The dollar amounts spent for medical insurance in this country certainly is a sufficient amount. The problem is it is maldis-

tributed. Some people have insurance that allows them the luxury of overutilization in the system. Many don't have it, and there is underutilization.

A redistribution of the benefits, along with some adjustments in what people might be able to do in terms of creative policies, I believe will go a long way toward alleviating the fact that some Americans, through no fault of their own, have no health insurance. That is one of the commitments I hope everyone on this Committee will join me in saying; that as soon as possible, notwithstanding the political season, and if we aren't able to make law in this area, certainly major strides in structuring a program that will answer the question of why Americans don't have insurance. There is no reason why they shouldn't, based upon the amount of money spent in the system.

With that I would recognize the gentleman from New York for questions, if he wishes to inquire.

Mr. RANGEL. Thank you, Mr. Chairman. The matter of $134 billion and the difference in estimates between CBO and OMB seems rather cavalier in view of the fact that throughout the debate on the floor and the Senate, the cost of the bill was of great concern to Members of the House.

It seems like we are dealing with two different governments and we are—the professionals that are making the estimates don't talk with each other, don't share the same basis for making their estimates. Now, we thought over here that OMB and your office knew there would be a much, much higher cost in this program than the figures given to us by CBO.

When did you first know, Mr. Secretary, that the differences would be in the range that we find today?

Mr. THOMPSON. We knew all along, Congressman Rangel, that our assumptions were higher. We assumed that there were going to be more participation in the plans than with CBO. We made that view known, but the changes were made right up until the end. The day before it was reported out, there was an estimate by CBO that the cost was going to be $360 billion.

The conferees decided that they were going to reduce the deductible, increase the benefits and lower—reduce the doughnut hole. That changed our assumptions. Our actuaries didn't know that and didn't have that information. This was the day before it was reported out of the conference committee.

The second thing is our actuaries—and I testified to this a couple of times—based their estimates on only the three bottom plans to be utilized. The committee voted that it would not be limited to three plans. As a result of that, our actuaries indicated that the cost would be more. That information was known.

The final assumptions were not made until after the conferees had reported out, and it was sent to the floor of the Senate and the House to be voted on. We did not get a final number from our actuaries until December 24th. I made that known to OMB at that particular time before Christmas, before I left. That was when we got it. Those assumptions were changing right up to the day that the bill was reported out of conference committee.

Mr. RANGEL. Well, the President always talks about this subject being so important that he wanted a bipartisan bill before the

House. When did you first know that House Democrats were not involved in the conference since these estimates were discussed? When did you first know that we were barred from the conference?

Mr. THOMPSON. Well, Congressman Rangel, I was in that conference committee. I knew that you came in one day and were upset that you were not allowed to stay.

Mr. RANGEL. Well, you are being very kind, Mr. Secretary, but you tell the President, if you will, that he ought to have more meetings at the White House so that Democrats would have some idea of how these things happen.

Mr. THOMPSON. Thank you.

Mr. RANGEL. Thank you.

Chairman THOMAS. The gentleman from Illinois, Mr. Crane wish to inquire?

Mr. CRANE. Thank you, Mr. Chairman. I want to express my appreciation that you are here with us today, Mr. Secretary. As you know, health savings accounts were made available to all Americans when the Medicare Prescription Drug Modernization Act was signed into law. I see that the President has included a proposal to allow people to buy high-deductible health insurance in conjunction with a health savings account and the ability to deduct 100 percent of their premiums from their taxes.

Mr. Secretary, do you believe that allowing individuals to deduct the premiums of a high-deductible plan will encourage the use of those plans and health savings accounts, and, in your opinion, would this tax deduction have a significant effect in reducing the number of uninsured in this country?

Mr. THOMPSON. I believe that health savings accounts are going to be one of the better parts of reforming health insurance in America. I believe very strongly that health savings accounts are going to be very advantageous. I believe there is going to be a lot of participation in those particular accounts. I think it is going to help us reduce the uninsured. I am going to push very hard to make that an accomplishment.

Mr. CRANE. Very good. One of the key goals of H.R. 1 was to improve health care choices for Medicare beneficiaries. In that spirit, we included a provision in the new law that requires drug plans to allow seniors to choose a 90-day supply of drugs at their local pharmacies when a 90-day supply of drugs is available through their drug plan's mail order operation.

It was clearly the intent of Congress to improve seniors' choices by creating a level playing field between local pharmacies and mail order. I hope that when HHS implements the drug coverage portion of this law that you will work to make sure that drug plans do nothing to intentionally discourage seniors from choosing a 90-day supply of drugs from their local pharmacies. I am especially concerned that drug plans may attempt to steer seniors to their mail order businesses by requiring higher co-pays or other cost sharing just for choosing to obtain a 90-day supplement from their neighborhood pharmacy. That was not the intent of this Committee, and I urge you to be vigilant in preventing plans from doing this. Do you have any specific plans for preventing this from occurring?

Mr. THOMPSON. Well, we are going to be very vigilant, as you have admonished us to be, Congressman Crane. We are going to use the procedures to make sure that that does not happen. We are very aggressive in making sure that seniors are treated properly and correctly, and we want to make sure that we carry out the will of the Congress and the will and intent of this Medicare Modernization Act. We will do everything we possibly can to prevent any kind of scamming that may possibly be considered.

Mr. CRANE. Well, thank you very much, Mr. Chairman—or, excuse me, Secretary. Let me commend you for all of the outstanding work that I think you have been doing. Keep the faith, fight the fight.

Mr. THOMPSON. Thank you very much, Congressman Crane.

Chairman THOMAS. The gentleman from California, Mr. Stark, wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. I—I thought as long as you are putting things in the record, I would ask unanimous consent that we put in the record a letter from the National Taxpayers Union, a group with whom I rarely agree. They wrote a letter to Secretary Thompson suggesting that we ought not to have the $12 million advertising campaign. That is, for a variety of reasons, a waste of money. I would ask that that go in.

Chairman THOMAS. Without objection.

[The information follows:]

National Taxpayers Union
Alexandria, Virginia 22314
February 5, 2004

The Honorable Tommy Thompson
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

On behalf of the 350,000-member National Taxpayers Union (NTU), I write to request that the Bush Administration immediately terminate the planned $12.6 million ad campaign on behalf of the forthcoming Medicare prescription drug benefit. We also ask you to cease all other publicly funded expenditures on items such as mailings and meetings which seem to be little more than public relations efforts to build support for this expensive new program.

Given that the heart of the new program doesn't begin until 2006, it is very hard to draw any conclusion about advertising this year other than that it is focused much more on the coming elections. While your "Same Medicare, More Benefits" campaign may be welcomed by politicians running for election in 2004, we can see little public benefit from a campaign beginning 2 years prior to the commencement of prescription drug insurance.

Even when there is no election agenda, NTU and fiscal conservatives across the country deplore taxpayer-funded advertising promoting big government. The outrage is compounded by your Department's recent embarrassing admissions that the prescription drug program will cost far more than what was promised to the American public last fall. These revelations are no surprise to NTU or the 45 citizen, taxpayer, and conservative groups from around the county who joined us in opposing this measure. Our broad coalition repeatedly warned wavering Members of Congress that this would be the case (supporters, of course, assured otherwise). We believe these belated admissions of the true cost provide one more reason to shut down all HHS advertising efforts.

The Medicare prescription drug legislation has added trillions to the unfunded liabilities facing the nation. This $12.6 million ad campaign, timed in accord with the

2004 elections rather than the start of the program, adds insult to injury, and we believe the American public would be best served by its immediate termination.

Sincerely,

John Berthoud
President

Mr. STARK. Also, I would like to go back to this 2-page brochure that you put in the record, and just point out—and see if the Secretary is aware of that—it says that all people will be able to enroll, all people with Medicare will be able to enroll in the plans. Isn't it a fact that it is limited to a 6-month window, and there could be significant penalties if they come in after that?

Mr. THOMPSON. There is a 6-month window. Yes, there is, Mr. Congressman.

Mr. STARK. Then you talk about a premium of $35 a month, and I am curious as to where you got that amount.

Mr. THOMPSON. That is the assumption by the conferees, the assumption by CBO. That was also the assumption made by our actuaries at CMS.

Mr. STARK. But it is not in the law anyplace?

Mr. THOMPSON. It is not in the law.

Mr. STARK. That is kind of a guess as to what it might be. It could be $150 a month, could it not?

Mr. THOMPSON. We are looking at our figures and statistics. It is our best judgment and expertise from our actuaries that it will be $35, Congressman Stark.

Mr. STARK. That is of the actuaries, not from CBO?

Mr. THOMPSON. That is correct. It is also the actuaries at CMS, but also at CBO as well. Both of them. That is one area that they are pretty much in agreement on.

Mr. STARK. Well, I can go on, but there are in here—I would like to add to the record an annotated issue here. For example, you mentioned a wellness physical exam. Although you do suggest that it is within the—when you first enroll, but other seniors currently enrolled aren't eligible for that benefit, are they?

Mr. THOMPSON. These are for new enrollees.

Mr. STARK. You do state that, I must add. Also on the drug savings card, the discount card, I understand you have had quite a few applications for different drug plans. Again the—the news release on August 30th from your Department suggested that the discount card will yield an average of 10 to 13 percent, possibly 15 percent. Wasn't that your August 30th release?

Mr. THOMPSON. If you have the release, it speaks for itself. I can't remember what I did on August 30th, Congressman.

Mr. STARK. I guess that the 25 percent, because it is on average, which is terribly misleading, Mr. Secretary, and I am sure you know that, because some drugs aren't covered at all by these plans and some drugs that are very rarely used are covered to a greater discount. I just—I find in here a little bit of lack of truth in advertising.

Then on the—and I will tell you that many of us feel that you had suggested that congressional staff heard about the actuaries' estimates. We didn't on our side, and I think you know that. Scully

said he wouldn't tell us, and he didn't. Our staff was told they would have the information, and never received it. Perhaps the majority did receive it. It is not exactly fair, and I would defy anybody in your Department to show where any of us, except perhaps for the two Democrats who are allowed in to the conference, ever received any of those estimates that the actuaries had done last summer.

Scully, we can beat up on him because he is gone to millionaire's land now down on K Street, but he said in the press that he wasn't going to allow us to have access to the actuaries anymore, and I suspect that is perhaps still in law.

So, I would hope that as we go along, the Chairman and the Administration can pass any bills they want next year. So, if we have reliable information, maybe we can share it and come to a better agreement. I would certainly hope that the openness with which actuaries have shared information on both sides of the aisle in previous Administrations, and when the Democrats controlled the House, would continue. It ended last summer. I don't think there is any question about that. Maybe it ended on both sides of the aisle.

To shield that kind of information, I think, prevents us from getting the kind of information we need to make reasonable decisions or to have reasonable debate. I think that might—that same criticism might come from some of my more conservative colleagues on the other side of the aisle. I just hope that we could, as we go forward, have open access to actuarial estimates and we could—they could be shared, and that we could then debate policy and debate the outcome of these bills, using facts that all of us could agree on. Thank you, Mr. Secretary.

Mr. THOMPSON. Thank you. Can I just quickly respond, Congressman Stark, on a couple of things? First off, the conference report language on low-income outreach, it states, and I will quote very quickly:

"The conferees expect that in carrying out the annual dissemination of information requires that the Secretary will conduct a significant public information campaign to educate beneficiaries about the new Medicare drug benefit to ensure the broad dissemination of accurate and timely information."

That is in the report language, plus it is also in the body of the law.

Second thing. I cannot speak for Tom Scully; nobody speaks for Tom Scully, as everybody knows. He indicated to me that he was disseminating information.

Third. I did, when I came up to the conferees, I did talk about some of the assumptions that our actuaries were making which were different than CBO. The CBO is the scorer for legislation by Congress, as you well know.

The fourth thing is I think we should try and be more cooperative. I will tell you that my Department tries to reach out to Democrats and Republicans on both sides of the aisle as often and as best that we possibly can. We will continue to do that as long as I am Secretary, Mr. Stark.

Mr. STARK. Thank you very much.

Chairman THOMAS. Thank the gentleman. Prior to calling on the gentleman from California, Mr. Herger, I would relate to the Secretary my long and arduous explanation to the previous Administration as to why the 1–800–Medicare number could be one digit longer than is necessary so it wouldn't be 1–800–Medicar.

The correct phone number aspect is 1–800–Medicar, but why in the world would you confuse someone by simply not adding another digit that would make it 1–800–Medicare. If any of you want to test this on a phone, you can actually punch one or more additional numbers following the minimum number necessary to trigger it, and it has no effect.

It took us over a year to convince those bureaucrats that 1–800–Medicare was a better number than 1–800–Medicar. Sometimes progress is measured very minimally. The gentleman from California, Mr. Herger, wish to inquire?

Mr. HERGER. I do. Thank you very much, Mr. Chairman. I am going to join in welcoming you, Mr. Secretary. I also want to thank you for your leadership not only with the Bush Administration, but as Governor of Wisconsin in the area of welfare reform.

Mr. THOMPSON. Thank you.

Mr. HERGER. As you are aware, welfare is up for reauthorization this year. Even though the House has passed it out twice, we are still having problems in the Senate getting it out. I like your comment on something. It has to do with the fact that even though the 1996 Republican welfare reform has been arguably one of the most successful social programs in our Nation's history, as is witnessed by the fact that dependence has fallen by unprecedented numbers, caseloads have fallen by 9 million; from 14 million to 5 million today. Child poverty rates are down sharply.

Since 1996 more than 2 million children have been lifted from poverty, including the black child poverty rate falling to historically low levels.

Even with all of that, as you know, and working with you, we still have much that can be done. There is still some 57 percent of recipients who are not working or being trained. There are still far too many families that are breaking up or not even—or yet not forming to begin with.

Mr. Secretary, if you could tell us, what are the American people, and especially the 2 million families still on welfare today, losing by our failure? Again this seems to be our problem in the Senate, not so much in the House, but failure to pass our legislation improving the 1996 welfare reforms.

Mr. THOMPSON. Well, first let me thank you for your leadership in this area, Congressman Herger. You were truly the instrumental leader this year, and I thank you and applaud you for what you have been able to accomplish.

You read the statistics, and I think those statistics bear out that it is very important for us to pass the reauthorization of the TANF law. What we need to do is, we need to give people the opportunity to work; the opportunity to get out of poverty. You can't get out of poverty in America without working. It is so important for us to realize that.

When you look at childhood poverty, you see the reductions since the act of 1996 across the board. When you look at the fact that

even though there was a downturn in the economy last year, welfare caseloads still had a decline. Also in those States that—when before, pre-1996, those States that in the past welfare reform, even in those States that had better economic conditions and better unemployment, still saw increases in their caseload; whereas States that may not have had the best of time economically, that had reformed their welfare system, still saw a reduction in the caseload, which would indicate that the TANF law does work, will work, and especially for those still remaining.

It is important for us to recognize that, and it is important for us to move forward and get this law passed as soon as possible.

Mr. HERGER. If you could respond basically, what is it that is so needed to help those who still aren't working, in the new legislation? What is it, in other words, does the new legislation do that updates the old legislation to make it even better?

Mr. THOMPSON. The new legislation continues on the successes of the past, but also increases the number of work hours. It also increases the number of child support, and it also increases the amount of money for child care. All of these things are going to be beneficial for those people still remaining on welfare.

Mr. HERGER. Thank you.

Chairman THOMAS. Thank the gentleman. The gentleman from Michigan wish to inquire?

Mr. LEVIN. Welcome, Mr. Secretary. Let me just say a few things to try to clarify the record.

Mr. THOMPSON. Okay.

Mr. LEVIN. I deeply respect you, but some things that have been said here and said earlier, I think, just don't hold water. You knew—your actuaries were estimating the cost far higher than CBO quite early on, well before we acted on the Medicare bill, right? You knew that?

Mr. THOMPSON. We knew that the assumptions were higher.

Mr. LEVIN. You knew—you were told the amount was higher?

Mr. THOMPSON. No. We did not know the final amount because the final 2 days changed the direction of the bill.

Mr. LEVIN. Wait, wait, wait. Before that, your actuaries were saying, before the last couple of days, that the amount was higher?

Mr. THOMPSON. Our preliminary estimates were higher, yes.

Mr. LEVIN. You passed that on to the White House? Somebody did?

Mr. THOMPSON. Passed it on to——

Mr. LEVIN. Someone at the White House knew what your actuaries were saying?

Mr. THOMPSON. There were individuals in the White House that knew that our preliminary estimates were higher.

Mr. LEVIN. Whatever the reasons.

Mr. THOMPSON. Yes.

Mr. LEVIN. The public can't get into each and every detail right now. We acted on the assumption that was given to us and reiterated by the White House; we were talking about a $400 billion bill.

When the actuaries within your ranks knew that that wasn't correct, or was not likely correct, or their assumptions meant a higher figure, however you want to put that, that is point one.

Mr. THOMPSON. Can I respond to that, Congressman?

Mr. LEVIN. Yes, briefly.

Mr. THOMPSON. Okay. Just like the Balanced Budget Act (P.L. 105–33) in 1997, there was a $50 billion difference between our actuaries and the actuaries in CBO. Congress has to base their figures on legislation based upon CBO, and CBO still said $395 billion.

Mr. LEVIN. I know, Mr. Secretary, but the world should know there was a difference of opinion. The Administration wasn't bound by the CBO figures. There is a credibility gap in this Administration, and the failure to let the world know while we were debating this, what the figures were within the possession of the Administration was wrong, was wrong in my judgment.

Second, I just want to tell you I have read the ad that is on TV, and one place it says, can I keep my Medicare just how it is? Now, look there is a deep difference of opinion about that, a deep difference. Mr. Stark has led out some of the differences. The taxpayers I represent, they resent your using taxpayer dollars to say what you think when others disagree, whatever was in the 1996 brochure, and we can go back and see. To use millions and millions of dollars on a TV ad is wrong, is wrong; and I think maybe you know it is wrong.

Let me just say a word about welfare reform, Mr. Secretary. There has been a reference here to the Republican welfare bill, trying to politicize what happened. It was eventually signed by President Clinton, not by President Bush after he vetoed it twice because of inadequacies in day-care and child care. The problem now is that there has not been a true bipartisan effort. There wasn't one here in the House, and there is that problem in the Senate. That is why it stalled.

Let me ask you this. Under your plans, 5 years from now, how many uninsured do you expect there to be in the United States of America? There are now 42, 43 million. Under your plans, what can we foresee in the year 5 years from now?

Mr. THOMPSON. I don't know. I don't know if you are going to talk about my plan or——

Mr. LEVIN. The Administration's plan.

Mr. THOMPSON. Administration's plan. I think you are going to be able to in—5 years from now you should be able to cut the uninsured in half.

Mr. LEVIN. Okay. My time is up.

Mr. THOMPSON. I would like to be able to respond to a couple things. First off, the law requires me to do what I am doing as far as outreach. I read the appropriate legislation. The law——

Mr. LEVIN. Are TV ads required?

Mr. THOMPSON. It says that. It also says that R&D proudly disseminates information to discount drug-eligible individuals; requires the Secretary to broadly disseminate information to beneficiaries about the coverage options. That is in the law.

Mr. LEVIN. It requires a TV ad that says one position, when it is refuted or disagreed with, huge numbers in this House and in the Senate?

Mr. THOMPSON. I am just telling you that we are doing the best job we possibly can, and we put it out in open bids in 1993—or in 2003. In regards to the ad, I think the ad is straight on. I

think it tells the truth. I think it says what it does. You disagree with me.

The second thing I want to point out is that our actuaries did not know until the December 24th the final number of $534 billion. It was changed right up until the end. The two biggest changes that our actuaries had no information about whatsoever, Congressman Levin, were basically the following two. Number one, the conferees decided to reduce the size of the doughnut, reduce the discount from $275 to $250, and we didn't know that. It was a difference of about $30 billion that was put in by the actuaries in the last 2 days. The second thing is, our actuary said that if you would take the lower three bids that the amount of difference would be at least a $30 to $40 billion difference.

Mr. LEVIN. That is a substantial amount.

Mr. THOMPSON. Those are a substantial amount.

Mr. LEVIN. What I am saying is, you actually you knew all along——

Mr. MCCRERY. [Presiding.] Excuse me. If the gentleman would yield, the gentleman's time has expired. Mr. Secretary, it is always a pleasure to have you before our Committee. You do a great job, both here and in directing one of the most important departments of the Federal Government, so I commend you for that.

About the advertising, I was glad you pointed out that, in fact, the legislation directs the Department to spend, I believe, up to a billion dollars in advertising and promoting the new Medicare program. The reason we inserted that into the legislation, to make sure that the executive branch advertised and got the word out, is very simple.

This bill that we passed is the most significant change in the Medicare program since its inception in 1965. Certainly, I would hope all of us would want senior citizens in this country to understand the changes that have been made, what their options are going to be and to allow them to take advantage of some of the changes in the program that we think will benefit seniors. Otherwise, it will do no good.

So, while some may object to certain language or to the public relations that is being used by the Department, I would hope that no one would object to the goal of educating and informing seniors as to their options under this changed Medicare program that we will have in this country. I am glad that you are doing it. I have seen the ads on TV; I think they are excellent. I hope you will continue to develop ads, TV ads, which is probably the most effective way to get the word out in the community, get seniors talking about it. So, I hope you will continue to do that.

I want you to address something that has not been talked about today, but is talked about back in my district some. Certainly some of the opponents of the Medicare legislation have talked about this provision in a way that implies that if the provision weren't in the bill, drug prices for seniors would be lower. This is the provision which prevents the Federal Government from interfering in drug price negotiations between the Medicare drug plans and drug manufacturers.

To hear some characterize this provision, it would lead one to believe that this was put in there to keep drug prices high. What is

your comment, Mr. Secretary, about why that provision was in there and what its effect is? By the way, before you begin, I should point out that this same language was included in a number of Medicare drug bills introduced by both Republicans and Democrats over the last few years.

Mr. THOMPSON. The reason is that we do not administer the drug programs. There are independent companies that administer the programs, who will have the power to negotiate.

Our Department does not purchase the drugs. We administer the program. The pharmacy benefit managers (PBMs), the preferred provider organizations (PPOs), the health maintenance organizations (HMOs), those are the individuals that are going to have to negotiate with the pharmaceutical companies, and the biological companies, in order to reduce the prices. We do not purchase the drugs, which is the big difference between us and the U.S. Department of Veterans Affairs.

The Veterans Department administers the program, but they also purchase the drugs and give them to individuals. We don't do that.

The pharmacist gives the drugs, and the individual HMO or the PPO or the PBMs are the ones that give the drugs to the individuals. They are the ones that have to have the power to negotiate with the pharmaceutical companies in order to get the lowest price.

Mr. MCCRERY. Well, I am glad you mentioned the VA system because that is a good example of a government not only negotiating for prices, but also establishing formularies for the availability of drugs to veterans. In fact, as a result of the development of those formularies, there are a number of drugs that are simply not available to veterans, and this language in the bill also bars the government from restricting drugs on a plan's formulary. The CBO, in fact, Mr. Secretary, addressed this question specifically during the debate on this bill; and CBO said that by not having this provision on the bill, it would not reduce drug prices to seniors, in the opinion of CBO. The CBO went on to say, comparing this language to the Medicaid program, which has its "best price" requirement, if we were to impose upon the new Medicare language the "best price" requirement that we have under Medicaid, it would increase the bill's cost over 10 years by $18 billion.

So, Mr. Secretary, in fact, the language in the bill is there to try to provide the lowest prices for drugs to seniors and to allow the private sector to do what it does best—compete and negotiate and provide services at the lowest cost, the best value. So, thank you, Mr. Secretary, for explaining some of that to us. Please keep up your good work in the Department.

Mr. THOMPSON. Thank you, sir.

Mr. MCCRERY. With that help, I think we will deliver a good Medicare program to seniors. Mr. Cardin.

Mr. CARDIN. Thank you very much, Mr. Chairman. Let me just take issue with our Chairman. One knows that market share has an awful lot to do with pricing. If we were to negotiate market share on behalf of all seniors, it would bring about lower drug costs than if we allow it to be parceled out in the different regions of the country, relying upon the private PBMs. That is why I think just about every consumer advocate group believes that the provision

prohibiting you from negotiating with the pharmaceutical industry will work to the detriment of the American consumers and seniors in the prices of their drugs.

Let me just point out, if I might, I understand the need to educate and inform our seniors about this new law. It is complicated. They have to make decisions based upon their current coverage and what the anticipated benefits will be. It is important that you get information out now about the discount card, and then, as the plans become available, the options that our seniors have to enroll in those plans.

I understand Congress putting the education requirement in the law. I saw the ad for the first time this morning as I was exercising and watching TV, I saw it on network TV in Baltimore, and I would urge you to show these ads to independent groups who are not politically affiliated.

I saw the ad, and I thought for sure I was looking at a partisan political ad that was trying to convince people that what we did in Congress was good, not trying to educate or inform them, which is your responsibility. You don't want your agency to get involved in a political battle or in election-year politics; and I would urge you to get some independent reviews, because I think you have crossed the line on that ad—at least the one that I saw—because I thought it was too partisan and too political.

I want to touch on a couple of issues that are not partisan at this point. There is a provision in H.R. 1 that deals with TRICARE for 90,000 military retirees and spouses, 90,000 of which are caught in a situation that when Congress added TRICARE-For-Life for military retirees in 2000, they had the right to enroll in the plan if they were in Medicare Part B, but they are faced with late-enrollment penalties in Part B through no fault of their own.

We have included a provision in the Medicare bill that will allow them to enroll in Medicare Part B without penalty, but they need to do it by the end of this year.

You are required to issue regulations so that they can take advantage of the provision that was passed by Congress. This was not in the first set of regulations that your agency issued, and I know, I really do know that an incredible amount of work has been placed on your agency, particularly with regulations that you have to issue. Because of the time sensitivity here, I would urge that you give this a priority. It is important to our military families and I would urge you to get the regulations out as quickly as possible.

Mr. THOMPSON. Thank you very much, Congressman Cardin.

Mr. CARDIN. There is a second point I want to bring up. Let me just respond very briefly to Mr. Herger. I think you have been working with us on the welfare bill. There was a provision that for some reason was not included in the bill that would have made elimination of poverty a goal within the welfare system. We talked about that. I don't know why we didn't include it.

So, perhaps, as you work with the conferees, we can figure out a way, assuming the bill moves through the Senate, to correct that, because I agree with you that the next plateau for welfare reform should be to try to help families get out of poverty.

I might point out that there was just a GAO report that showed 20 some States have reduced their child care budgets because of

the local financial pressures on budgets, and another 10 or 11 are looking at cuts in child care. Your budget provides only a billion dollars more in the child care budget, not enough to stop the freezing of enrollments in my State. Unless you go on welfare, you can't get any child care help.

I would hope that we could find additional resources to deal with child care needs. If we are going to ask families to get out and work, which they should, and we want them to get jobs, and we want them to get job training, it is going to require safe and affordable child care. We don't have enough today, and a billion dollars more in mandatory appropriations will not be enough.

Mr. THOMPSON. Thank you very much, Congressman. Let me just respond quickly to a couple of the things.

In regards to the waiver of the Part B late enrollment penalty for certain military retirees, we will do everything we possibly can to get it done. I can assure you that we will, and I thank you for bringing it up to me.

In regards to comparing these ads, I was under the impression that other people did see them. I will go back, but it is my understanding they did. The lead contractor has been there since 2003. It is Ketchum Public Relations, and I believe everybody pretty much knows who they are. It was an open contest. They won it.

As I understand it, Ketchum's executive is Chuck Doland, who happens to be on John Kerry's finance committee, so I don't think he would be putting something out that is partisan. He is the one that is responsible for putting together the team.

Mr. CARDIN. I don't want either political party involved in these ads.

Mr. THOMPSON. It was an open bid, and it was peer reviewed, and Ketchum won it in 2003. It just happens that the lead person happens to be a Democrat, Congressman Cardin.

Mr. CARDIN. Well, I appreciate your willingness to check, to look at it. The one ad I saw, as I said, dealt solely with trying to——

Mr. THOMPSON. I think you are right. I think they should—I want them to be informational. I want to be able to get the information out to the seniors. I don't want them to be partisan. I want them to be able to do the job which the Congress wants us to do and to implement this law as fairly as we possibly can.

Mr. CARDIN. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Mr. MCCRERY. Before I call on Mr. Camp for questioning, I want to point out in response to Mr. Cardin's comments about all these consumer groups that are now saying that the non-interference language is so bad. It is curious to me that—and I mentioned this generally, but I will be more specific now—that a number of Democrat-sponsored bills contain the same language, and those were the Eshoo-Frost bill of 2000, H.R. 4607; the Stark 2000, when the Democrats promoted it as an alternative on the floor and 204 Democrats voted for it; the Wyden 2001, S. 1185; and the tripartisan Jeffords-Breaux-Landrieu 2002 in the Senate. So, it is just curious to me that somehow now the same language that was used on both sides of the aisle in the best interest of seniors is being denigrated. Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman. I want to thank the Secretary for being here and to thank you for the excellent job you do. I just have a quick comment on Mr. Cardin's comments earlier, that in H.R. 4 we did mention and we did add reducing poverty as one of the goals of the bill, in Section 401—I have the language here; I can share it with you—to try to make it a more bipartisan effort. So, I am hopeful that will answer that question.

I do want to mention about the non-interference language that Mr. McCrery brought up, that language is language that has appeared in a number of bills from both parties, really since the Daschle Medicare bill of 2000; the Eshoo-Frost bill in 2000; the Stark bill in 2000; the Wyden bill in 2001; the tripartisan bill that passed or that was introduced in 2002; and also in the Senate Medicare bill that passed in June 2003, which 35 Democrat Senators supported, including one of my own Senators from Michigan.

Really, I think the point is that the government doesn't negotiate prices, the government sets prices; and I think it is very important to have this language in there to preserve the competitive private-sector delivery system that we have in this country. That is why, I think, you have seen language in bills of both parties consistently over the years as we have tried to address this idea of a prescription drug benefit in Medicare that have included this language. So, I just wanted to make that point.

Also, Mr. Secretary, one of the provisions in the budget that hasn't received the most attention today, but I think is one that really will help many families make adoption easier is the income phase-out on the adoption credit. I just want to commend you for that and say that I think that will have a very positive result.

I just wondered if you had any idea how many families would benefit from this proposal, that actually simplifies the adoption tax credit and makes it possible for more families adopting children to take advantage of it.

Mr. THOMPSON. I can't give you a figure at this point in time. I am sure that I can go back to the Department and get some of our actuaries to give you a number.

I would like to tell you—first, to thank you for your leadership on the adoption bill last fall. It was an excellent one, and it is going to turn out to be an excellent bill to improve adoptions, especially for special needs children and especially those older children, over the age of 8. You led the leadership on it, and I thank you so much.

Mr. CAMP. Well, thank you very much. Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Mr. Camp, and I add my commendation for all your work on the adoption provisions. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Mr. Secretary, I know that sometimes things in our personal life are pretty tough to deal with, and my heart is with you today. Nevertheless, I want to ask a couple of questions.

Mr. THOMPSON. I know you will.

Mr. MCDERMOTT. I have to. You once said communities of color suffer disproportionately from diabetes, heart disease, Human Immunodeficiency Virus (HIV), AIDS, cancer, stroke, and infant mortality. Eliminating these and other health disparities is a priority of HHS. I have always considered you as being someone who was

among the more credible among the Secretaries in this Administration.

The recent record of the Administration is so bizarre that it is hard to find anybody that believes anymore. What is struggled with is that on the day before Christmas Eve, the National Institutes of Health (NIH) released its national health care disparities report, or it was released from HHS.

This was in response to a public law which demanded that you do this. It was given to the NIH, and they looked at the issue, and the investigation found that HHS substantially altered the conclusions of its scientists. In the June draft, the Department scientists found significant inequality in health care in the United States, called health care disparities "national problems," and emphasized that these disparities are pervasive in our health care system.

Now, for some reason, you took it upon yourself to rewrite this, and you came out with a version that refused to define disparity as had been done in the other one. The other one had had 30 references to "disparity." There were no references to "disparity," and it was left undefined.

Now, you even went to things like the Native American population in this country where you point out that they have a lower death rate from cancer. Well, that sounds like a pretty good deal, but what there was no mention of was that their overall life expectancies are significantly shorter than all other Americans, or their infant mortalities are substantially higher.

They went on with things like—the draft concluded that the racial and ethnic minorities are more likely to be diagnosed with late-stage cancers, die of HIV, receive suboptimal cardiac care. The final version dropped all these examples.

Now, I would like you to tell us who told you to rewrite this, because I can't believe that the man who made that first quote, that first statement about the disparities, could rewrite a report from the NIH.

Mr. THOMPSON. I didn't rewrite it, and thank you for bringing the question up. I would like to clarify that.

Mr. MCDERMOTT. Yes, please do.

Mr. THOMPSON. When it came to my desk a couple of weeks ago, I changed that order and put out the original report just the way it was, without any changes whatsoever.

Mr. MCDERMOTT. Well, could you explain to me how this happened in the first place? How do you go out and——

Mr. THOMPSON. I can explain it to you, but it is not something that I am very happy about. Some individuals, that thought they were doing the right thing, took it upon themselves to be more positive; and when it came to me I said, no, we will put it out the way it was. That is the way it is going to be.

Mr. MCDERMOTT. Well, that is what brought my attention was the quote from your spokesperson——

Mr. THOMPSON. That is how I feel, and that is how I believe. That is why it is going to go out in its original form, Congressman.

Mr. MCDERMOTT. I am stunned, and I appreciate your honesty.

Mr. THOMPSON. Well, I am honest.

Mr. MCDERMOTT. I think——

Mr. THOMPSON. There was a mistake made, and it is going to be rectified.

Mr. MCDERMOTT. The disparities in health care in this country are atrocious, and I think it shouldn't be a partisan issue, and I think it ought to be——

Mr. THOMPSON. It is not a partisan issue.

Mr. MCDERMOTT. If we don't admit it, we can't deal with it.

Mr. THOMPSON. You are absolutely correct.

Mr. MCDERMOTT. I think that the other thing that I have been concerned about, and that is the whole question of the ads. I looked at those ads. Well, I was watching the President on Sunday morning. I admit I got up, went down in my bathrobe to watch him.

Mr. THOMPSON. I bet you were cheering him on.

Mr. MCDERMOTT. Yes, I was. I thought it was great. Right in the middle I get one of these ads, and I couldn't believe that you would authorize that. All right, we know that you want to sell the product and advertising on TV is the way 90 percent of Americans find out what is going on; but that campaign really was over the top.

I find—like Pete, I find myself with the National Taxpayers Union, and I agree, there must be something wrong. I really think you ought to look at that. If you are going to keep putting that out there, you are going to pay for it, I think, in the end—not you, but politically your party will pay for that. You cannot misrepresent the situation in that way and expect to get away with that.

Mr. THOMPSON. Congressman McDermott, I respectfully disagree with you. I do not think we are misrepresenting it. I think we are very straight on.

I will go back and look at it again, but I am not the one that puts these ads together. I don't have that ability, Congressman. We hire people to do it. It is the same firm that has been doing it for the last 3 years, and it hasn't been changed. As I indicated, the lead individual that put the thing together happens to be a Democrat, and I don't think he would put out partisan stuff.

Mr. MCDERMOTT. Mr. Secretary, just one thing. It sounds like on the report from the NIH you were not the one who made the decision, and I have the feeling you didn't make the decision about these ads. I think that they were made somewhere else. They were never submitted to you.

Mr. MCCRERY. The gentleman's time has expired.

Mr. THOMPSON. They have my final approval. I am responsible.

Mr. MCCRERY. I thank the gentleman for his comments. I would point out to the gentleman from Washington that I agree with Secretary Thompson's decision to issue the report in its original form. As you and I have discussed, there are disparities among ethnic and racial groups in this country with the quality of health care they receive; and if you and I had perhaps ventured a little farther in our efforts to create a system in which everybody would have private health insurance, maybe we could solve those problems. Mr. Ramstad.

Mr. MCDERMOTT. I stand ready to work with you.

Mr. RAMSTAD. Thank you, Mr. Chair. Mr. Secretary it is always good to see my friend from Wisconsin, and I want to thank you for

doing a tough job very well. I want to shift gears, and I mean really shift gears to the recent National Survey on Drug Use and Health. I am sure you are familiar with the survey, which showed 6 million Americans are drug addicts, 17 million Americans are alcoholics. In the same year, according to the Office of Drug Control Policy, same year's survey, 3.5 million people were denied treatment for chemical dependency in America who were ready to take that first step and who needed help. That is why I am pleased the President's budget calls for $200 million funding for the access-to-recovery State vouchers to give people with chemical dependency access to the program that works best for them, a program of treatment which will hopefully start them on their recovery.

Last year, as you know, we funded half of the President's request. He also requested $200 million in last year's budget. We funded the program at $100 million for this fiscal year, and I am hopeful we can work together in a bipartisan way and fully fund this program. This is something that is desperately needed to deal with the epidemic of chemical addiction in America.

Last year, I know also, the Administration made a commitment to work with Congress to pass mental health treatment parity. In fact, the President stated publicly that he supports mental health treatment parity. This would include a study of the efficacy of chemical dependency treatment parity.

I would like to know, Mr. Secretary, what, if anything, is currently being done by the Administration to promote mental health parity, the bill sponsored by Senator Domenici in the Senate, and I have sponsored the companion bill in the House.

Mr. THOMPSON. Let me just start off by thanking you for your leadership in this area, because mental health parity is something that this country needs to get to. There is no question about it. How we get there, of course, is always the problem because of the financial implications. The President has come out strongly for it and as a result of that—he doesn't need to convince me—but my whole Department is pushing for it; and hopefully we can get legislation through Congress this year that will accomplish that.

Mr. RAMSTAD. As it now reads, is the Administration supportive of the Domenici-Ramstad bill?

Mr. THOMPSON. As of right now, I am certainly supportive of the concept. I don't know if the White House has taken a position on that particular bill, the concept the President has come out and endorsed.

Mr. RAMSTAD. I see one of your assistants shaking her head affirmatively, and that is a good sign. I certainly hope so.

You alluded to the cost implications of parity. Mr. Secretary, as I am sure you know, we have all the empirical data in the world. This issue has been studied to death for 20 years, both mental health treatment parity and chemical dependency treatment parity. We can prove—we have proven, rather; it is the RAND Corporation study or the Rutgers study or the Columbia University study or the Minnesota study or the California study.

We can go on and on. We can show that for every dollar we spend in treating people with depression and other mental health problems, for every dollar we spend treating people with chemical addiction, we save $7. We save $7. Everybody out there who is un-

treated for their alcoholism incurs health care costs 100 percent higher than I do, who has been treated for my alcoholism.

So, we don't even have to argue that this is cost effective. It is not only the right thing to do, but it is the cost-effective thing to do, and I am glad the President supports it. I am glad you support it, and I hope this year we can get it done.

Mr. THOMPSON. Congressman, all I can tell you is that everything you said, you speak from the heart and it is so true. The truth of the matter is, this whole country, if we are really serious—and I hope on a bipartisan basis we are—if we are really serious about getting health care costs under control, you have to start looking at prevention.

Number one, $155 billion for tobacco, 442,000 Americans die; $135 billion on diabetes, 200,000 Americans die; $117 billion on obesity, and over 300,000 Americans die; on alcoholism and so on down the line. If you really want to address health care costs in America, we have to do something about prevention, and that has got to be front and center.

I happen to be passionate about it. I talk about it all over the country.

I am so happy that you are out pushing in regards to alcoholism because you know absolutely how important it is and how important it is to get this information and word out. Whatever you can do to help me, and whatever I can do to help you, I am there.

Mr. RAMSTAD. Thank you very much, Mr. Secretary.

Mr. MCCRERY. Mr. Kleczka.

Mr. KLECZKA. Mr. Secretary, I have a couple of questions, going back to the Medicare program. Do you agree that currently we are reimbursing HMOs and PPOs who administer to Medicare patients higher than under the Medicare fee-for-service program?

Mr. THOMPSON. Yes.

Mr. KLECZKA. Do you know what that percentage might be or——

Mr. THOMPSON. I think it is 105 percent.

Mr. KLECZKA. Okay. About 5 percent. I am told that under this bill, and especially since the re-estimate of the costs going to insurance companies, that the difference in reimbursement will be about 120 percent. Do you agree with that?

Mr. THOMPSON. I disagree with that, Congressman Kleczka.

Mr. KLECZKA. Under the bill, how high do you think we are going to get?

Mr. THOMPSON. I think it was 106 percent.

Mr. KLECZKA. No, it is much higher than that. Well, the reason I bring this up is—I'm sorry.

Mr. THOMPSON. Our actuaries say it is going to be 105 to 106 percent, and they figured it would be about 98 to 99 percent if they would take the three bottom bids in the regions; and that is why we were advocating it.

Mr. KLECZKA. The reason I bring that up is because currently we are reimbursing insurance companies higher than the Medicare fee-for-service, and it seems that one of the reasons we had to pass this bill, which I did not support, was because we had to save Medicare. Well, how do you save Medicare—save it from going bankrupt? How do you save Medicare by going to a system where

you are paying more for your reimbursement to companies, versus the current system? That just doesn't add up in my mind.

The other question and concern I had, Mr. Secretary, is in questioning from Mr. Crane from Illinois, you indicated your support of the health savings accounts and also your support of the President's proposal to have the premiums for these high-deductible policies totally tax deductible; am I correct? Did I hear right?

Mr. THOMPSON. I didn't answer on the premiums.

Mr. KLECZKA. Okay. Well, it seems that the President is recommending that these types of health care premiums be totally deductible from the income of the individuals. Do you not support the current premiums we are paying to also be deductible? I guess that was the link I tried to establish here.

Mr. THOMPSON. I support the budget as advanced by the President, Congressman.

Mr. KLECZKA. Okay, but it seems ironic that this one type of special health care premium is going to be treated more favorably than the health care premiums that the balance of Americans pay, and I think there is something wacko with that policy, and hopefully this Committee will make it—if, in fact, it is pursued, will make it much more fair for all Americans who are paying health care premiums. Thank you.

Mr. THOMPSON. I tend to agree with you, Congressman.

Mr. MCCRERY. Does the gentleman yield? It seems so. Ms. Dunn.

Ms. DUNN. Thank you very much, Mr. Chairman, and thank you, Secretary, for being with us today. We all appreciate your resiliency in working with us to interpret what is a very complicated piece of legislation; and I know we will all work together over the next few months and years as we make sure that some of the elements that are important to us do not slip through the cracks. We appreciate your working with us.

A lot of us on this Committee are very interested and concerned about the 44 million people who remain uninsured, and we are looking for a way to provide them access to health care coverage. Because of the characteristics of the uninsured—many of them work for companies, but they are different size companies—it is tough to come up with a single approach to provide their insurance coverage. There is interest in refundable tax credits, not just for individuals but also for small companies, and I am wondering—you have taken a shot at this from different angles.

Could you just summarize some of the thoughts you have to help us provide for affordable health care coverage?

Mr. THOMPSON. Thank you for the question. There are several things I think we should do.

The first thing, I think we should try and move a lot faster toward a more uniform system as far as a computerized system for practicing medicine. We could reduce the number of untimely deaths and accidents considerably. We are in the process of doing that in the Department, setting up a uniform system called SNOMED, which we are going to license and give out to clinics and doctors.

I think we should take the President's plan on tax credits. I think we should then expand that and allow States to set up for

all those that are uninsured into a purchasing pool—it would be a very good pool—and have the State set up an insurance commission or commissioner that would negotiate for that particular tax credit for the State of Washington.

The State of Washington may have 2 percent of the total tax credit. If they got that into an uninsurable pool and had one individual to do it, you would have a lot of companies that would bid for the individuals that are uninsured, and then you would have a very acceptable rate for the uninsured to purchase it.

The third thing is, you could have a stopgap loss at over $7,500 in insurance policy from 75 to 25 percent and would be affordable, and it would be able to reduce the number of uninsured considerably.

The next thing you should do is you should try and do something about the Community Health Centers to be able to make sure that we are able to get more Community Health Centers across America. If you do those three things, you can reduce the uninsured and allow a lot of access to individuals that need health insurance in America.

Ms. DUNN. Thank you very much. The second question——

Mr. THOMPSON. The final thing is, if we are ever going to get control of this, we have to be serious about prevention.

Ms. DUNN. Yes, and we have discussed that on this panel. Let me ask you a question about reimportation. As part of the Medicare Prescription Drug Act, Congress directed several departments to work together and to conduct reports on reimportation, and I am wondering—there were some guidelines that were proposed in the legislation. I am wondering how that reporting is coming. What efforts has your Department taken to deal with counterfeit drugs that are entering the United States?

Mr. THOMPSON. Well, the U.S. Food and Drug Administration (FDA) has taken a leadership role, Congresswoman Dunn, and they have had a couple of incidents in which they have stopped drugs coming into America in order to find out what kind of drugs are coming into America and how many are counterfeit drugs and how many are mislabeled and so on. The percentage is very high.

I can get those facts and figures for you. I don't have them off the top of my head, but it is basically in the area of 75 to 80 percent of the drugs that were stopped by FDA agents coming into America were either mislabeled or counterfeit drugs or were the wrong type of drugs, or the directions on the packaging.

[The information follows:]

The task force has been convened and held its first meeting with consumer groups on March 19th. The task force is chaired by Dr. Carmona, the Surgeon General. See the attached press release for additional information on the task force, its members and its agenda.

FOR IMMEDIATE RELEASE
Tuesday, March 16, 2004

Contact: HHS Press Office
(202) 690-6343

HHS Names Members to Task Force on Drug Importation

HHS Secretary Tommy G. Thompson today named 13 people to serve on the new Task Force on Drug Importation that is exploring how drug importation might be

conducted safely and its potential impact on the health of American patients, medical costs and the development of new medicines.

Surgeon General Richard H. Carmona will serve as the task force's chairman. The panel includes representatives from across HHS, as well as from other parts of the federal government with knowledge or involvement in drug importation issues. The task force may consult other federal officials as well.

"Under Dr. Carmona's leadership, this task force will fully examine the issues surrounding drug importation to determine how to assure consumers that such imported drugs are safe and effective," Secretary Thompson said. "We haven't been able to provide those safety assurances as required by law and with available resources. The task force will study if drugs can be imported safely and, if so, what resources would be needed to ensure safety."

Secretary Thompson also announced the dates for the task force's five listening sessions with groups and individuals who would be affected by drug importation. The first meeting will take place Friday, March 19, and will feature speakers from at least a dozen invited consumer groups.

The dates of the other listening sessions are: April 2 with health care purchasers; April 28 with professional health care providers; May 6 with industry representatives; and May 14 with international stakeholders.

In addition, the task force will hold a public hearing on April 14 to allow members of the general public to present their views on the issue. The hearing will take place in the Natcher Auditorium at HHS' National Institutes of Health in Bethesda, Md. Information about participating in the public hearing is available at *http://www.fda.gov/OHRMS/DOCKETS/98fr/04n-0115-nm00001.pdf*.

"Secretary Thompson asked the task force to assess the issue of drug importation safety and the associated public health issues," Dr. Carmona said. "I am looking forward to working with task force members as we conduct a fair and objective evaluation based on the best science and information available."

In addition to Dr. Carmona, the task force members are:

- Jayson P. Ahern, assistant commissioner in the Office of Field Operations, U.S. Customs and Border Protection, Department of Homeland Security.
- Alex M. Azar II, HHS general counsel;
- Josefina Carbonell, HHS assistant secretary for aging;
- Lester M. Crawford, D.V.M., Ph.D., FDA deputy commissioner;
- Elizabeth M. Duke, Ph.D., administrator of HHS' Health Resources Services Administration;
- Mark B. McClellan, M.D., Ph.D., incoming administrator for HHS' Centers for Medicare & Medicaid Services;
- Mike O'Grady, HHS' assistant secretary for planning and evaluation;
- William Raub, HHS' deputy assistant secretary for public health emergency preparedness;
- Tom Reilly, public health branch chief at the White House Office of Management and Budget;
- Amit K. Sachdev, acting FDA deputy commissioner for policy;
- Elizabeth A. Willis, chief of the Drug Operations section, Office of Diversion Control, U.S. Drug Enforcement Administration; and
- Colette Winston, a trial attorney at the Department of Justice.

The task force's members ultimately will offer recommendations to Secretary Thompson on how best to address the key questions posed by Congress as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The legislation directed HHS to complete a study by December 2004 to address the following issues related to drug importation:

- Identify the limitations, including limitations in resources and in current legal authorities, that may inhibit the Secretary's ability to certify the safety of imported drugs.
- Assess the pharmaceutical distribution chain and the need for, and feasibility of, modifications in order to assure the safety of imported products.
- Analyze whether anti-counterfeiting technologies could improve the safety of products in the domestic market as well as those products that may be imported.
- Estimate the costs borne by entities within the distribution chain to utilize such anti-counterfeiting technologies.
- Assess the scope, volume and safety of unapproved drugs, including controlled substances, entering the United States via mail shipment.
- Determine the extent to which foreign health agencies are willing and able to ensure the safety of drugs being exported from their countries to the U.S.

- Assess the potential short- and long-term impacts on drug prices and prices for consumers associated with importing drugs from Canada and other countries.
- Assess the impact on drug research and development, and the associated impact on consumers and patients, if importation were permitted.
- Estimate agency resources, including additional field personnel, needed to adequately inspect the current amount of pharmaceuticals entering the country.
- Identify the liability protections, if any, that should be in place if importation is permitted for entities within the pharmaceutical distribution chain.
- Identify ways in which importation could violate U.S. and international intellectual property rights and describe the additional legal protections and agency resources that would be needed to protect those rights.

A public docket for the task force will be opened tomorrow to allow members of the public to submit comments for the record. The docket, 2004N–0115, will be available at
http://www.accessdata.fda.gov/scripts/oc/dockets/comments/commentdocket.cfm.

Ms. DUNN. Is it your feeling that people incur a great danger when it comes to safety if they go across the borders to purchase drugs?

Mr. THOMPSON. I can't say that, Congresswoman Dunn. I am just talking about drugs that were—that we stopped coming into this country at the border. I don't know—safety of people going across the border, we haven't stopped anybody going across the border, and I don't think we are—there is no intention ever to do so.

Ms. DUNN. Those drugs that you inspect, is that a particular type of drug or are you just randomly inspecting?

Mr. THOMPSON. Random drugs, Congresswoman.

Ms. DUNN. Thank you. Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Ms. Dunn. Mr.——

Mr. THOMPSON. Congresswoman, just if I could, there was a 3-day blitz at four airports last year. The FDA identified more than 1,100 unapproved drugs coming in from Canada and many drugs that because of labeling storage or other problems presented safety risks.

Mr. MCCRERY. Mr. Lewis.

Mr. LEWIS OF GEORGIA. Thank you very much, Mr. Chairman. Mr. Secretary, welcome.

Mr. THOMPSON. Thank you, Congressman.

Mr. LEWIS OF GEORGIA. It is good to see you. I want to raise one or two questions. One on the line that Mr. McDermott—we have all these reports, we have all these studies, and you come here every year and we hear all this debate and concerns about the health disparity between the majority population and the minority population.

Do you have any information, any data, that would demonstrate that we are making some progress? Is the gap continuing to grow and widen? Are we narrowing the gap between the minority and the majority population when it comes to basic health care?

In addition, I would like for you to tell me what is your vision or what is the vision of this Administration in improving the quality of health care for all of our citizens?

Mr. THOMPSON. Well, Congressman, my vision is very simple. I want to make sure that we have uniform access to every man, woman, and child that has a medical problem to be able to get access to that medical care, whatever his race or background may be.

I believe very strongly that we have set up an institute at the NIH that is working extremely hard in order to reduce the disparities across America. We are doing lots of research. A lot of research is being done on minority health at NIH and the Centers for Disease Control to make sure that we are much better prepared in order to treat minority diseases.

As you know, I just took over the chairmanship of the world global fund to fight international AIDS. I just came back from Africa, where I spent 10 days in five different countries in Africa, talking to individuals on how we might be able to implement our programs better from the global fund to fight AIDS.

We are expanding the Ryan White program in this budget in order to fight AIDS, especially in minority communities, where we are still seeing a spike-up; and I am very much in opposition to that and hoping that we are going to be able to get a handle on that and get the information out there to minorities in order to protect themselves.

I have teamed up with Tom Joyner, as you probably know, every September to take a loved one to a doctor and especially African Americans. We are putting out our literature and our information on Medicare, as well as most of our health statistics and health documents, Congressman Lewis, in English as well as Spanish, so that Hispanics are able to get the same kind of information as possible.

I speak on this subject across the country to many different minority groups. We are reaching out. Whether or not we are having the effect—I think we are. I think we are very aggressive. My Deputy Secretary is doing a wonderful job in regards to this issue; I have assigned it to him because he certainly knows this issue as well as anybody does, and we are trying to look for any kind of input from you or anybody else on how we can do the job better.

We can always do a job better. We are always looking for ways to do it better, and we will continue to do so as long as I am Secretary.

Mr. LEWIS OF GEORGIA. I appreciate that very much, Mr. Secretary.

Let me just ask you a question about the new Medicare prescription drug bill. In your heart of hearts, do you really believe that this bill is a good deal, a better deal for the poorest of the poor? It seems like in some cases, in many of the States, people are going to have to pay more. In the State of Georgia——

Mr. THOMPSON. Congressman Lewis, this is a very good bill for the poorest of the poor. Those individuals under 100 percent of poverty are going to be able to get all of their drugs paid for for free. There will be no deductible. They will have no co-pays whatsoever.

Mr. LEWIS OF GEORGIA. It appears to me in the State of Georgia about 129,000 of the poorest beneficiaries are going to have to pay more. I think this would be true in several other States.

Mr. THOMPSON. No. Those under 150 percent of poverty, 97 percent of those individuals under 100 percent of poverty are going to have all their drugs paid for. Those under—between 100 and 135 percent, 91 percent are going to have it paid for; those between 135 and 155, 75 percent. It is a wonderful bill for those low-income sen-

iors in America that have had to make a choice between purchasing this or purchasing drugs.

Mr. LEWIS OF GEORGIA. Well, I appreciate your response. Let me just—before my time runs out let me ask you about something else. Now, on the morning that we voted on this bill——

Mr. THOMPSON. Yes.

Mr. LEWIS OF GEORGIA. Between 3:00 a.m. and 6:00 a.m., my eyes didn't fool me; didn't I see you on the floor of the House?

Mr. THOMPSON. Yes, you did.

Mr. LEWIS OF GEORGIA. Yes. Do you think it was proper and appropriate for a member of the Cabinet to be going from chair to chair, aisle to aisle, lobbying Members of Congress to vote on the bill? Do you think that was proper? Did you promise anyone anything?

Mr. THOMPSON. I didn't promise anybody anything.

Mr. LEWIS OF GEORGIA. Well, what were you doing there? Technically, you could be there, but to me it seemed like it is—you are coming down. Seems like it is belittling the Secretary of HHS or a member of the Cabinet to be going person to person, almost knocking on doors, almost asking for votes. That didn't look good.

Mr. THOMPSON. Congressman Lewis, I spent 5 months working on this particular bill. I think it is a very good bill. It is very good for low-income Americans. I think it was only proper for me to be on the floor. Nobody told me I shouldn't be there.

I wanted to see it passed. I worked very hard to get it passed. I believe it is the right thing, and I think in years to come people are going to look back and say this is a very good bill.

Mr. LEWIS OF GEORGIA. I thank you, Mr. Secretary. Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Mr. Lewis. Certainly, if there was anyone in the Administration who could have been considered an expert on the legislation that was before the House at the time, it was the Secretary of HHS. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman. I concur with that, Mr. Secretary. I have heard several of the comments you were making there and you were just explaining the provisions of the bill to encourage those who may not have fully decided what to do on that bill.

I was pleased to hear you make some comments about the Community Health Centers. We have one down in the Columbus, Georgia, area, which is in south Columbus with a lot of minority residents; and it has done a very good job for the local residents there. We appreciate your help in that area.

In the last few days, as I have traveled through the district and have spoken with many oncologists on the phone about the cancer drugs, they are concerned about the delivery of those drugs, based on the way the reimbursement now will be on the average wholesale price (AWP). They are concerned that those who have more clout in buying will be able to buy at a much lower rate than the physicians who actually administer in their offices, and that that is going to put an imposition that many of them will have to then send their patients to the hospital for this type service. I am not sure how that reimbursement will stack up with the hospitals get-

ting other benefits because of the visits and how the comparison will be on what it actually costs through the Medicare system.

What do you see in 2005 is some information that we can share with the oncologists as to how this is going to be addressed? What approach we are going to take to make sure that people are not forced into a hospital that may be miles away from where they normally have been going for their care, because of the way that was configured in the Medicare bill?

What can you give us to be able to pass along to these oncologists that their patients will be well taken care of and that they will be reimbursed at a fair rate to administer the drug?

Mr. THOMPSON. Thank you very much, Congressman Collins. First off, thank you so much for your leadership on Community Health Centers. Your Community Health Center in Columbus, Georgia, is one of the finest in the country, and I intend to get down and visit it with you, hopefully this summer or this coming fall.

In regards to oncologists and the drugs, this was one of the very complex and complicated pieces of the legislation; and what we were doing, we were overpaying for the drugs in the past and underpaying for the delivery of the drugs by the doctors. What we are trying to do is to increase the amount of money that doctors would receive for giving the drugs and put the payment for the drugs more in line.

As you know, it is going to be AWP, but then it is going to be the average sale price in 2005.

We are setting up the procedures, and we are looking at that; it is a very complex thing. We are having a lot of input from the cancer doctors and clinicians across the country. We are having a lot of input from individuals like yourself on both sides of the aisle, and we will continue to do so, and I will keep you informed as we go along.

All I can tell you is, we are trying to be fair. We are trying to put it more in line with what the costs of the drugs are, for the proper reimbursement as well as improving the reimbursement for doctors so that they can get paid for their services in a more equitable fashion; and they haven't been in the past.

Mr. COLLINS. Well, I sure hope so. We were speaking with one earlier this morning, and this particular doctor referred to a particular drug that he uses that has a cost, and he used the number of $2,100. Based on the reimbursement fee, he would actually get 80 percent of $1,800 or somewhere around $1,500 with a net loss of $600. I don't know if the fee for the administering is going to offset such a difference in cost there of the drug itself.

So, that is the thing that we are running into, and we are hearing a lot about, and I hope you will keep a very open mind.

Mr. THOMPSON. It is a real balancing act, and we are looking at this. We are trying to come up with the best balance possible. We know that there is a lot of criticism out there, and we are trying to find ways in which we can come up with a more equitable system, Congressman Collins. The best I can tell you is that we are working on it and we will keep you informed.

Mr. COLLINS. Very good. Very good. Well, that's all we can ask. We appreciate it very much, and please stay abreast of it. We do

look forward to your visit in the Columbus area for the Community Health Center there, maybe sometime in August or early fall.

Mr. THOMPSON. Thank you very much, Congressman.

Mr. COLLINS. Thank you.

Mr. MCCRERY. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman, and thank you for rolling those Rs so well. Mr. Secretary, pleasure to see you again. Thank you very much for your testimony. I want to say what I said to you right before we began as well. Thank you very much for the work that you have done that many Members of Congress on a bipartisan basis have done to try to deal with the issue of diabetes. I think we recognize that it has become a crisis, and it is something that is preventable.

So, I want to thank you for working hard on the part of the Administration to include within the recent Medicare bill some provisions which I think were instrumental in helping many people who are either suffering from or could get better or perhaps control it and live a longer life. So, I want to thank you for that.

I want to get into the advertising issue a bit, because I think that goes into the—goes to the question of credibility. I think when it comes to seniors, they depend on us to give them the truth and explain to them exactly what we are going to do. So, I know that questions have been asked by some of the Members to you directly, and I know that taxpayers would like to know how the $23 million for the advertising campaign is going to be spent.

Is the information that Members have requested with regard to how the money is being used, what programs are being sent out, where, whether, is all that information about the advertising campaign going to be provided to the Members?

Mr. THOMPSON. Absolutely.

Mr. BECERRA. Okay. Any idea when we will get that?

Mr. THOMPSON. We can get it to you tomorrow.

[The information follows:]

By statute, CMS is required to provide education to beneficiaries. CMS specifically chose to include television advertising in our campaign because our research has shown that Medicare beneficiaries receive the majority of their information from television, making it the most effective and efficient medium for reaching the Medicare audience.

On February 3, 2004 CMS launched a nationwide advertising campaign, "The Right Answer," to alert beneficiaries of the new benefits that are available under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). This included newspaper print, radio, and television ads in both English and Spanish which direct beneficiaries to the Internet site, www.medicare.gov, and the toll-free number anyone can call at 1–800–MEDICARE. The toll-free number has customer service representatives 24 hours a day, seven days a week. Due to the controversy surrounding this very issue, the GAO conducted an analysis on whether our ads were political advertisements. While I did not believe these ads to be politically charged, I had agreed to pull the ad if the GAO's findings determined that it was indeed "a political advertisement." I am happy that GAO did not find this to be the case.

The ad was developed by our contractors and directs those interested in finding out more information about the new benefits to the toll-free 1–800–MEDICARE number or Medicare web site. The cost of the winter ad campaign was $12.6 million, the cost of the television ad buy which was part of that campaign was $9.5 million, and the cost of the beneficiary mailing that includes the Secretary's letter and MMA fact sheet was $10 million.

Mr. BECERRA. Great. Appreciate that very much.

Mr. THOMPSON. It is more than $23 million. There is a total of $1 billion that the Congress put in the Medicare Modernization Act, Congressman, for the implementation, for the information and for putting together this very complex piece of legislation. We are going to have to purchase some new software. We have some software that is older than the technicians that are administering it.

Mr. BECERRA. I think there you are going to find that all of us, on a bipartisan basis, are going to be asking you to move as quickly as you can to get us into the modern age to communicate and provide information. I think what many of us are expressing is that some of these advertisements that we have seen don't seem to give much information, other than perhaps sell the program that passed, which many of us had a great deal of concern about, especially because most of the provisions of the bill don't take effect until 2006.

So, to spend what I thought was a campaign so far of about $23 million in taxpayer funds for an advertising campaign for a program that really won't start for another year and a half or so, when most of the folks that are hearing this for the first time will have forgotten, it just seems misplaced. I think a number of us are concerned that it is not really going to have the effect that you want to try to educate the public and, certainly, seniors.

Mr. THOMPSON. We have to get the information out about the card. The card is going to be rolled out in May, in June of this year, so——

Mr. BECERRA. I am looking at this, a full-page advertisement, and I see only one brief mention of the card. So, if it is about the card, there is a full page that could have been used to give seniors a big——

Mr. THOMPSON. As I said, we can't wait until next year. We have got to get moving right now.

Mr. BECERRA. Well, again, that is where I think a number of us think if it is really to get the information out about the card, the discount card, then let's have something that really does give information about the discount card, not just touts the bill that passed.

Nothing really says here that most of these provisions won't take effect until 2006. So, I think some seniors who look at this are going to be somewhat deceived, believing that they can just call this 1–800 number and find out how quick—for tomorrow, how they can enroll.

I don't think anyone wants to do that. That is why I think there is some—much caution being raised by some of us on the issue, as I mentioned before, with regard to this advertising or just the general issue of credibility, I think at this stage.

Now we are starting to hear that we went to war in Iraq, and it wasn't for the reasons that the President articulated. We find that the Supreme Court is taking on a case right now where the Vice President of the United States has been unwilling to reveal discussions he had with energy executives about energy policy that was going to set the policies for this country for years to come. We found that we had an energy crisis that followed and certainly, my State, it hit hard. That energy crisis follows many of those discus-

sions that took place in the White House between Vice President Cheney and some of these energy executives, which included people from Enron and other companies.

I think people want us to be credible. It seems difficult sometimes to fault the American people if they think that we are not being credible or that the country is heading in the wrong direction.

We don't see how we are trying to tackle the fact that we have lost more than 2 million jobs over the last 3 years. We don't see what we are doing to try to help the 44 million Americans, most of them living in a working household, that don't have health insurance.

I am wondering if you can give us a sense of what we are going to do today for the 44 million people, for example, who are uninsured, and the close to what is 80 million people who, at some point this year, will not have any health insurance and trying to tackle their dilemma of providing health care to their children and their families.

Mr. THOMPSON. I mentioned it to Congresswoman Dunn when she asked the question. I think what we need to do is we need to build upon the President's tax credit provision that is in front of you in this budget, the tax credits of about $75 billion.

What I would like to do is have each State be assigned a portion of that tax credit, have the governors put all those uninsured in a particular State into a purchasing pool, allow this governor to set up a commission or a commissioner to negotiate with the insurance companies. It would be a very viable pool because one-third of those individuals are under the age of 25. A good share of those are making over $50,000 and just don't believe in purchasing health insurance. So, you have got an insurable risk. You have got some that are going to be very difficult to insure, but if you put them all together, you are going to have a good risk pool, and you get the companies to bid on that. Then you would have a stopgap loss, and then you would be able to put out a bid for those individuals and you should be able to get a lot of individuals that you could get covered with health insurance.

Mr. BECERRA. If those tax credits that you are talking about max out at $3,000 and the average premium for a family is over $9,000, how are we going to make the——

Mr. THOMPSON. You didn't listen to me. I say you put all these people into a pool. Then it would not be $9,000 for an individual. The insurance companies committed bid for that whole pool, and it would be very low. Then you would be able to have individuals subscribe, an individual and a couple.

Mr. BECERRA. So, that is going to begin to happen this year?

Mr. THOMPSON. Well, that depends upon you. If I can get bipartisan support, we can get it passed. I have got the plan laid out. I can lay out a plan here that we can do it. All I have got to have is enough support in Congress to get it passed.

Mr. BECERRA. You are already over budget $140 billion on what you have told us the Medicare bill cost.

Mr. THOMPSON. No, CBO is still $395 billion.

Mr. BECERRA. Mr. Chairman, thank you very much.

Mr. MCCRERY. Thank you. Mr. English.

Mr. ENGLISH. Thank you, Mr. Secretary. Perhaps to change the tone a little bit, I would like to, first of all, thank you for a number of the commitments you have made, including taking the time to be on the floor of the House of Representatives when we debated that very difficult Medicare bill, one that I think required your expertise to be there to explain to Members if they had questions. I, for one, find it a little unusual and have a taste I will leave others free to qualify, that anyone would criticize you for doing that.

Second of all, I would like to congratulate the Department for launching the advertising campaign that, in the Medicare language, was specifically laid out as one of your responsibilities. I think it is critical at this point, given all of the conflicting stories that seniors have seen about this Medicare program and this Medicare benefit and the card that is going to be available soon, that they have access to objective information. That is all that you are providing and I have seen the ad. It gives a number that people can call. I think it is entirely appropriate as a use of public dollars that we reach out to seniors and make them aware of what their options are now, and what is going to be available to them in the future.

So, I want to salute you for doing that. Again, it may be that some who voted against the legislation or some of the interest groups that opposed the bill may be on record opposing the advertising, but I don't see what any legitimate concern would be in making the information available.

On another matter, Mr. Secretary, as you know, the law provides for an update to hospital wage indices at given intervals. One such update occurs after the decennial census numbers are tabulated and implemented. Given that 2000 census hasn't been completed, but the wage indices have not yet been updated as a result of this census, I wonder, first of all, if you could explain the process in which HHS must undergo to complete this decennial update to wage indices; and second of all, what is a typical timeframe for completing this process, and have there been any circumstances this year that could have possibly extended the time necessary to complete the decennial update?

Mr. THOMPSON. We are still analyzing. It is still in CMS. We are going to be using the census data, and all I can tell you is that we will keep you informed, Congressman. Thank you for your kind words.

Mr. ENGLISH. Well, I am very grateful to you for indicating that you will keep us informed. I wonder in your opinion, Mr. Secretary, do you feel Congress could exercise its authority properly in order to streamline this process for future decennial censuses?

Mr. THOMPSON. Absolutely. We can give you some recommendations.

Mr. ENGLISH. I look forward to those. As you know, for example, in Mercer County Pennsylvania, a number of our local hospitals, which are now included in the new Standard Metropolitan Statistical Area with Youngstown, have not yet received the higher reimbursement that that status would imply. That, in turn, affects the quality of health care and services to seniors in that area. I know this is not a unique situation, but it is certainly very close to home for us. Mr. Secretary, anything you can do to make that

process move forward and expedited we would be eternally grateful to you.

Mr. THOMPSON. Thank you very much.

Mr. ENGLISH. I guess my final question has to do with the question of homelessness. Recently, one of our local TV stations in Erie has focused on the real problems that local providers have run into with primarily State funding for homeless programs.

I notice that the President has offered a new initiative in this area called the Samaritan Initiative. I wonder if you could comment on how the Samaritan Initiative potentially could plug some homes in the safety net?

Mr. THOMPSON. The funds are going to be awarded competitively to support the most promising collaborative strategies, such as the one that was publicized on your Erie TV station. It is to provide chronically homeless people with permanent housing in support of services. My Department is very involved in setting up supportive services, and we have some plans for them to do that much more uniformly across America than has ever been done before.

Mr. ENGLISH. If I can. I want to also offer to work with you in this process.

Mr. THOMPSON. Please.

Mr. ENGLISH. As you navigate this initiative through the very tight budget this year, we think homelessness is a very serious issue. The real problem, including in some of our mid-sized communities in America, and we do think that there is a compassionate, conservative way of getting at the core of this problem. I salute you for being a leader on that point.

Mr. THOMPSON. Thank you very much. I am Chairman of the Intergovernmental Task Force on Homelessness. We are coming up with a report, I believe in August or September on it. I will keep you informed.

Mr. ENGLISH. Thank you, Mr. Secretary.

Mr. MCCRERY. Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. Mr. Secretary, it is good to see you again, and I want to thank you for working with my office and Senator Conrad's office in getting clarification of the wage index issue, straightened out in the wake of the passage of the Medicare bill.

The record you have established in your own public service as a well respected Governor, is that the initiatives you brought online, you paid for them. One of the things that concerns me about the Medicare package, which I supported, is how we sustain the benefits in light of a deteriorating, in my view, an alarmingly deteriorating fiscal situation in the United States.

Does it concern you, in light of the record deficits and the aging of the population, the baby boomers set to retire next decade, that there might not be the fiscal wherewithal under this path to continue these benefits?

Mr. THOMPSON. It concerns me because I am a member of the trustees for Social Security and Medicare. As Mr. Chairman pointed out, the trustees meet in March. After the March meeting, I believe he is going to have the actuaries from both CBO and from CMS come here to testify together.

Yes, it concerns me a great deal. Last year at our trustees meeting, Congressman Pomeroy, we had a pretty vigorous discussion amongst the trustees about the direction of Medicare and Social Security. At that time we projected out that there was going to have some real serious problems come 2014 and 2012. With added benefits there is going to be an acceleration of that.

There is a provision in the Medicare law that says that once Medicare—once Medicare starts taking 45 percent of the gross domestic project budget, say about 33 percent now, goes to 45 percent, the trustees have got to project out when it is going to hit that.

Then it has got to back off 7 years from that. So, if it is going to be 2016, the year 2016, which is what the conferees had suggested was possibly the date, the drop-dead date for doing some action by the trustees would be fiscal year 2009. So, there is a trigger in there to start alerting Congress, the President, and the administrators about the time to start addressing Medicare about the cost and about ways to fund it.

Mr. POMEROY. Is it your position that as we consider revenue items in this Congress that might have a very significant revenue impact in terms of revenue lost next decade that this might be something we have on our minds already?

Mr. THOMPSON. I think you always have got to consider the revenues. You have also got to consider the tax cuts, how they stimulate the economy and how the economy is going to hopefully continue to grow and create jobs and be able to bring more money into the coffers.

It is always, I believe, the best hope for a country and an economy is to keep it growing and expanding so that there is more revenue coming in. I think that has got to be the basis under which we operate.

Mr. POMEROY. You are not suggesting that we look at only the short-term stimulus effect and ignore the long-term?

Mr. THOMPSON. I happen to be one of the long-term believers, especially in my role as fiduciary responsibility as trustee, Congressman.

Mr. POMEROY. The final area of inquiry I would have, Mr. Secretary, gets to some funding of designated programs very important to rural health care. One of the reasons I believe the Medicare bill passed was because it at last addressed funding inequities to rural hospitals.

Mr. THOMPSON. This was an excellent bill for rural America.

Mr. POMEROY. It absolutely was. I agree with you on that, was pleased to co-author the amendment that improved it in that respect that we passed in the Committee on Ways and Means.

The cuts in rural health outreach network development grant programs, the rural hospital flexibility grant programs, and the small hospital improvement programs collectively go from $94.6 million to the recommendations if the budget of $11 million, that is especially to phase out the third program. Two of the three are zeroed out, the third is phased out. That is a real setback to rural medicine. It looks to me a bit like on the one hand, we address the issue, on the other hand you make the issue a bit worse with these types of cuts to programs vital to rural hospitals.

Mr. THOMPSON. I understand, Congressman. You have got to realize that I come from a very rural area of the State of Wisconsin, and I am a champion of rural health from my legislative days through governorship to when I was Secretary.

When you compare, there has to be some reductions in all of the programs in order to get us within the 1.5 percent limit under which OMB gave us. When you compare the huge increase at $25 billion and a loss of $30 million, the overall huge increases in reimbursements for rural hospitals is going to just dwarf the reductions that were made on the discretionary side.

Mr. POMEROY. My time has expired. I have got some issues to take with that, but not this go-around. Thank you, Mr. Secretary.

Mr. MCCRERY. I thank the gentleman for staying within his 5 minutes time.

Mr. HULSHOF. I am sorry, did the gentlelady from Ohio have a comment?

Ms. TUBBS JONES. My question was, you don't regular order on your colleagues, so why on my colleagues?

Mr. HULSHOF. I have been here for——

Mr. MCCRERY. Regular order.

Mr. HULSHOF. I appreciate that.

Mr. MCCRERY. Members will resume.

Mr. HULSHOF. I want to move away from some of the political themes sounded by others. Mr. Pomeroy, that is not a reflection of your questions. I appreciate the tone of your questions.

I do want to, and I do—you explained at length, Mr. Secretary, for those of us that were here to hear it, the differences between your actuaries and our official scorekeeper, which is the CBO.

I would like to ask you if there are any differences on this issue of non-interference? Back home, in Missouri a lot of folks are asking questions about why can't Medicare set price controls or set the price of drugs and implement price controls?

Mr. Chairman, I am not sure if it has been asked to be submitted in the record, but I would ask that a letter from the Director of CBO dated January 23rd, to Senator Frist be included for purposes of this part of the discussion.

Mr. MCCRERY. Without objection.

[The information follows:]

Congressional Budget Office
Washington, DC 20515
January 23, 2004

Honorable William H. Frist, M.D.
Majority Leader
United States Senate
Washington, DC 20510

Dear Mr. Leader:

At your request, CBO has examined the effect of striking the "noninterference" provision (section 1860D–11(i) of the Social Security Act) as added by P.L. 108–173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. That section bars the Secretary of Health and Human Services from interfering with the negotiations between drug manufacturers and pharmacies and sponsors of prescription drug plans, or from requiring a particular formulary or price structure for covered Part D drugs.

We estimate that striking that provision would have a negligible effect on federal spending because CBO estimates that substantial savings will be obtained by the

private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree. Because they will be at substantial financial risk, private plans will have strong incentives to negotiate price discounts, both to control their own costs in providing the drug benefit and to attract enrollees with low premiums and cost-sharing requirements.

If you have any questions we would be happy to answer them. The CBO staff contact is Tom Bradley.

Sincerely,

Douglas Holtz-Eakin

cc: Tom Daschle, Democratic Leader
Honorable Don Nickles, Chairman, Committee on the Budget
Honorable Kent Conrad, Ranking Member
Honorable Charles E. Grassley, Chairman, Committee on Finance
Honorable Max Baucus, Ranking Member
Honorable Jim Nussle, Chairman, House Committee on the Budget
Honorable John M. Spratt Jr., Ranking Member
Honorable William "Bill" M. Thomas, Chairman, Committee on Ways and Means
Honorable Charles B. Rangel, Ranking Member
Honorable W.J. "Billy" Tauzin, Chairman, Committee on Energy and Commerce
Honorable John D. Dingell, Ranking Member

Mr. HULSHOF. The non-interference provision, basically as you know, Mr. Secretary, we prohibit you or other secretaries of HHS from setting these prices.

Do you agree, or does the CMS agree with the conclusion of our scorekeeper that says essentially as follows: striking the non-interference provision would have a negligible affect on Federal spending because CBO estimates that substantial savings will be obtained by private plans, and that the Secretary, referencing you, would not be able to negotiate prices that further reduce Federal spending to a significant degree. Do you agree or disagree with that assessment?

Mr. THOMPSON. It is hard just to say agree or disagree because, Congressman, CBO has assumed that the repeal of the non-interference yields no savings. Our actuaries have not even addressed this particular subject as such. Until they do, I would like to have the input from them to determine if there is going to be a huge cost factor. They are the actuaries that I have to rely upon.

Mr. HULSHOF. We will take that answer as——

Mr. THOMPSON. I will be more than happy to get an answer to you in regards to our actuaries very quickly.

[The information follows:]

The office of the Actuary has reviewed the issue and, based on their preliminary assessment, believes elimination of the non-interference provision would have a negligible impact on the cost of the Medicare prescription drug benefit.

Mr. HULSHOF. You had a very sincere, and I thought passionate exchange with Mr. Ramstad earlier about preventive care and wellness. I think certainly within the bill as passed, as far as dealing with chronic care, as you know, and again, I think everyone on the Committee knows, perhaps those who don't know the intricacies of Medicare, who may not understand, is that basically the Medicare program, as it currently exists before the implementation of those reforms, is largely a bill payer.

Mr. THOMPSON. Uh-huh.

Mr. HULSHOF. Really there are no programs or there is no guidance to assist older patients, depending upon Medicare on focusing on wellness or how to manage chronic illnesses.

What general statements can you make as far as what this bill does, especially as it relates to the number of hospitalizations or perhaps home health visit or doctors visits or helping those that have chronic illnesses, not only help the system be in a better financial health, but more importantly, help our senior citizens remain in better personal health.

Mr. THOMPSON. Congressman, your question is so appropriate. Thank you. I have been hoping that somebody would ask me that question. Right now we spend 92 percent of our dollars in Medicare waiting for you to get sick. Then we spend that hundreds of thousands of dollars to get you well again; and less than 8 percent of the dollars to keep you well in the first place.

Anybody that is developing a system like that would say that is wrong-headed. What we are trying to do, and the provision that I happen to like the best in the bill, is the one that I worked with Congresswoman Johnson on, is the preliminary physical, a baseline physical for people that come into Medicare.

When you come into Medicare, right now, 125 million Americans are suffering from more than one or more chronic illnesses, that spend 75 percent of the costs of medical dollars goes for those illnesses. Most of those illnesses can be prevented or reduced or mitigated.

What we are going to do with the baseline physicals, we are going to be able to get people in there. We are going to find out how sick you are. Then we are going to start treating those sicknesses before they come to such an exaggeration that you have to spend thousands of dollars to get you well. You will make the lives and quality of health better in America, you will save dollars, I am confident, and you will finally start addressing preventative health in America.

Mr. HULSHOF. Thank you.

Mr. MCCRERY. Ms. Tubbs Jones.

Ms. TUBBS JONES. Thank you, Mr. Chairman. Mr. Secretary, thank you for acknowledging my sorority, and welcome.

Mr. THOMPSON. Are they still here?

Ms. TUBBS JONES. Some of them. They have been here all day. They are probably watching TV with baited breath as we ask you questions. I was about to ask you about the ability to negotiate best price, but my colleague has already asked the question, and you don't seem to have an answer that you are willing to give at this point. I would love to have you give a response at some point about pooling all of the seniors in the United States into a pool to purchase drugs at a lower cost. At some point I would love to have an answer from you. More importantly——

Mr. THOMPSON. Congresswoman Jones, the problem with that is that, is we don't have the pooling concept. Because all of the private—the HMOs, it is the PPOs, it is the PBMs that are going to be negotiating, it is not me.

Ms. TUBBS JONES. Those of us who supported a different piece of legislation suggested that was the better means of providing prescriptions to senior citizens.

Let me—I want to focus in on the health disparities piece, because you have talked about how important it is to you. I have been to a couple of events where you have received awards for the work that you have done in health disparities, but I have some concerns about what appears in this particular budget.

The budget, as I read it, cuts the public health improvement account in half. This is reductions to accounts that not only jeopardize electronic information, but also affect programs to eliminate racial disparities. Your current budget eliminates most health professional training programs by slashing spending on these programs from $294 million this year to $11 million in fiscal year 2005, which is a 96-percent cut.

Let me speak specifically to the Public Health Services Act (42 U.S.C.), Title 7 and Title 8, where there are health career opportunity programs, the centers for excellence and minority fellowship faculty programs. All of these programs which were pushed by my predecessor, the Honorable Congressman Louis Stokes, who is known across the country as being the person who has pushed to see that minority health care is addressed.

It goes on to freeze funding for maternal and child health, preventive health and healthy start programs, which are very preventive issues. You continue to discuss prevention. Clearly the prevention you are talking about in Medicare will be dealing with seniors that are already 65 or 70, so a whole lot of prevention that is going to happen at 70 versus prevention that can happen at an earlier age.

Can you tell me why would you cut the programs that were providing opportunities for minorities to get into medical school? We know that in the studies that have been done, that culturally sensitive physicians are helpful in allowing people to really be clear to their physicians about health care. Can you tell me why, when you are talking about the need for disparity, dealing with health disparities that you would cut the very basic programs that are important to providing health care professionals for minority communities?

Mr. THOMPSON. We thought it was a better way to put the dollars into programs that are going to put scholarships, and in the program for the national service corps, to get doctors of color to go into areas that really need it.

We think that it is a much better way. We think that program that you are talking about is good. We just think putting the targeted dollars, the little bit of dollars that we have into areas that are going to pay for minorities to go to school, and then take the responsibility or sign a contract to go out into areas, into minority communities to Indian reservations, to areas that really need the kind of coverage. That—this directs those scarce resources to places that really need it. That is the difference.

Ms. TUBBS JONES. The difference is—there should not be scarce resources, and that every member of the medical profession should be directed to help minorities, they shouldn't just be minorities that are directed to the minority communities. That minorities

ought to be spread—there should be neurologists, cardiologists, radiologists, and so forth, to work in minority communities.

All I am saying to you, Mr. Secretary, is in a program that was significant for building health professionals for minorities, please do not stick me just in a particular community and rank me in that area.

I appreciate your response. The yellow light is about to go. Maybe you and I can have an opportunity to sit down and talk about these discussions.

Mr. THOMPSON. Why don't you come on over?

Ms. TUBBS JONES. I would love to. I would love to offer some legislation that you might get your Republican colleagues to support on my behalf. Thank you.

Mr. THOMPSON. Stop over and have lunch and see my operation.

Ms. TUBBS JONES. Thank you.

Mr. MCCRERY. Mr. Weller.

Mr. WELLER. Thank you, Mr. Chairman. Thank you for your time and patience and perseverance today in appearing before our Committee. It is a pleasure to work with you. I also want to commend you and the President for your leadership on health care issues. Both parties have talked for years about providing prescription drugs under Medicare, and the President's leadership and your leadership——

Mr. THOMPSON. For 12 years.

Mr. WELLER. We got it done. For that I commend you. I also commend the President on the Association Benefit Plans proposal which has passed the House, we are waiting for the Senate to address. I particularly want to focus my questions in my limited amount of time on success that you have been making, with the support of us in Congress, on Community Health Centers.

As you noted in your testimony, with the support of the Republican Congress, in the 3½ years of the Bush Administration, the Administration has funded 614 new and expanded Community Health Centers in this country, helping low-income families and individuals, effectively increasing access to health care for an additional 3 million people.

That is a 29-percent increase over when George W. Bush became President. For that I congratulate you, because I am a strong believer in Community Health Centers. I think the Will County Community Health Center just a few miles from my home, and the families and the people that have been served, and the health care that is available through there.

I note in the President's budget you request an additional $218 million for Community Health Centers, another record increase in funding for Community Health Centers, which we agreed to last year, and providing a record increase in this past year. The President has a goal of doubling the number of Community Health Centers, having around 1,200, and I certainly stand in strong support of that.

As you look at this year's record increase in funding, what role do you see for Community Health Centers in addressing issue of the uninsured?

Mr. THOMPSON. They are the first line of defense for those individuals that are underinsured or uninsured. It also gives sort of a comfort level for people you know that are fearful of going to a large institution, going to a hospital or going someplace else. They feel uncomfortable because their neighbors go to the Community Health Center, they have known somebody that has been there that has been treated well.

Plus, the health care, the medicine that is practiced in these Community Health Centers are really outstanding. The doctors that we have, and the nurse practitioners and the nurses in Community Health Centers are some of the best and compassionate people that we have in our society. So, you get good treatment. There is a comfort level. A plus they are there across the country to give people the access that they need to get their medical needs taken care of. I can't say enough about them. I thank you for your leadership and support for accomplishing even bigger and better times for Community Health Centers.

Mr. WELLER. Well, I certainly agree with you, they have a tremendous role. Again, the Will County Center just a few miles from my home, serves hundreds and hundreds of families. They do a wonderful job. They are expanding, thanks to the support of this Congress. One of the concerns I often hear, though, from some of the health centers that are in Illinois is the issue of reimbursement.

Mr. THOMPSON. Yes.

Mr. WELLER. For providing care to Medicare patients because of a CMS imposed payment cap. We have raised this issue before, and it is an issue I would like to work with you on to ensure that they are adequately reimbursed. I was wondering if you had any thoughts on that, because obviously if we want to provide quality care we have to provide adequate reimbursements for Community Health Centers.

Mr. THOMPSON. Well, we did try a minimum per capita payment, but we are always looking for ways to improve the system. I have found, being in politics as long as I have been, that some of the best ideas that I get are going out to places that are asking for the services, in this case Community Health Centers, and just talking to them and finding out what the problems are, but at the same time finding solutions.

If you can work with us, our doors are wide open. Dennis Smith is here, who is the acting head of CMS, and we would love to work with you. If you have got any good suggestions how we can improve, let us know.

Mr. WELLER. Thank you. Thank you, Secretary. I certainly support President Bush's and your goal of doubling the number of Community Health Centers serving America. I am certainly interested in working with you on this reimbursement issue. So, thank you, Mr. Secretary.

Mr. MCCRERY. Thank you, Mr. Weller. Mr. Tanner.

Mr. TANNER. Thank you, Mr. Secretary, for being here and for your patience. I am sorry I had to be out for a minute. I think we have had a good discussion about the present, Mr. Secretary, but what I want to ask about is the future.

Mr. Snow, the Secretary of Treasury was here last week. It used to be we talked about the solvency of the Social Security system and Medicare. Some of us are now worried about the solvency of the country.

The budget that has been submitted, although we know that the hope is to get to half of the yearly deficit in 5 years, never balances, and we know what the demographics are beyond that time. I am, Mr. Secretary, truly concerned about the financial solvency of this country. The situation is such that if you read the comments in the London Financial Times, you read what the G7 is saying about our situation, you know that Asian banks are considering pulling out of their currency of choice being the dollar.

You know that we have a $500 billion trade deficit. We also realize that the true deficit this year, once one takes out the Social Security receipts is really on the order of $700 and some odd billion rather than $500 billion.

My question really is, given your fiduciary relationship with the Medicare and Social Security systems, is there any advice you could give to this Committee, or what advice do you have with regard to the long-term picture? I am just beside myself.

I told Secretary Snow, it looks to me like we were in a death spiral if we were in an airline, and unless something happens, we are going to hit the ground. Herbert Stein said what can't go on forever doesn't. At some point we are going to be so burdened with interest payments on the debt, that there is not going to be much of anything left to finance Medicare, Social Security, or anything else for that matter.

I realize the short-term consequences of hard political decisions, but in your March meetings that you alluded to earlier, is there any hope that we can get some recommendations, maybe we can't act on them this year because everybody knows what kind of shape we are in in this town this year.

I know speaking for some of us, we are willing to do virtually anything to try to stop this, what I call death spiral of debt, and the attendant carrying charges called interest.

Nobody says that is a tax increase, but it is probably the largest tax increase we could put on the American people, when one considers that every trillion dollars that we borrow is a $40 billion obligation that year and the year thereafter and every year thereafter, for which we receive virtually nothing in terms of services, and for which 37 percent of it is being presently bought and held by foreigners as we write checks for interest on the obligations that the Treasurer auctions off from time to time.

So, could you give us some insight as to what you believe might come out of these discussions based on the long-term, because I think the short-term speaks for itself. I don't see how we can continue to forecast deficits every year with no hope of balance, given the demographics of the country, as well as what is happening in the world with respect to our trade deficit.

So, with that, let me just ask for your help, advice or insight. Thank you.

Mr. THOMPSON. Well, first, thank you, Congressman Tanner. That was a well thought-out question, and I appreciate that very much. I appreciate your passion on the subject.

I am concerned about Social Security and Medicare, because that is my fiduciary responsibility. I can see serious problems coming. I believe that the Medicare Modernization Act was the first step toward recognizing the problems, and you and I can differ on that.

Let me just elucidate a little bit. First off, it is the first time we have indexed Part B deductibles. That is a step in the right direction. We had income related to Part B premium, which is another thing that is going in the right direction.

We got a 45-percent trigger that got into Medicare, not as tough of a trigger as I was proposing, but it is still a trigger. I think that the trustees are very concerned, and agree with some of your assumptions in regards to the importance to address Medicare in Social Security in the future.

I think Congress is going to have to address Medicare and Social Security. They are going to have to. There is no other question. I think that maybe not this year, but 2005 and 2006 are years in which I think this country has got to start facing up to looking at ways and how we are going to finance Medicare and Social Security, especially with the demographics. I happen to agree with you.

Mr. MCCRERY. Thank you, Mr. Secretary. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman. It is great to see you, Secretary.

Mr. THOMPSON. It is always a pleasure to see you, Paul.

Mr. RYAN. It was snowing a lot in Wisconsin this morning. So, it is nice and warm here. So, nice to see you here rather than Wisconsin today.

Mr. THOMPSON. Thank you.

Mr. RYAN. I have a couple of specific questions on the new Medicare law. Number one, I want to talk about quality; number two, I want to ask you about some of the Medicare advantage plans that grow out of those. One of the most important parts of this bill I think and others have said it, are the new health savings accounts. That empowers consumers to be consumers, but you can't be a good consumer in the health care marketplace if you are not equipped with good knowledge of quality and price. So, that is why the quality initiative that is in Medicare legislation with respect to hospitals, in particular, I think is so important.

Where is—where is the agency on the quality initiative? I know that you have a couple of dates that you have a choice to pick when the quality initiative is rolled out; at the beginning of the summer or at the end of the summer, I think.

Otherwise, if the hospitals don't meet I think their market baskets, they won't get the full update. Could you give me a quick summary on where you are with the quality initiative, and are there any other quality and price data rollout initiatives that you are contemplating over there at the agency? Then I have a quick follow up.

Mr. THOMPSON. Well, first off, the Department has set up a whole plethora of rollouts as far as quality are concerned. We have the nursing homes, the comparison in nursing homes, which is up and running, which wasn't even thought of until 3 years ago. We started it under my leadership, and we are doing things with the home health. We have got some new quality initiatives on home health. We are going to do something on hospitals.

In regards to the Medicare, the acute care hospital payments updates, that is going to be one where data is going to have to be submitted for the most recent available calendar quarter of discharges for both Medicare and non-Medicare discharges. I can give you a whole package of these things, but right now we are still working on implementing them.

Mr. RYAN. Are you going to do the hospital initiative at the beginning of the summer or the end of the summer?

Mr. THOMPSON. June 1st.

Mr. RYAN. Great. That is good news. Second question. The Medicare advantage plans. I am just curious at your response that you have gotten from the market that is out there, the PPOs, the HMOs and the other types of plans that would be offering plans. Obviously, they are going to want to see what the regions are going to look like before they really get serious about taking a look at offering plans to areas. So, question one is, where are you on getting these regions set up? Have you begun to get the rough sketch of the regions?

Number two, I am just curious, what has been the reaction in the private sector with respect to the advantage plans kicking in, especially with the PPOs?

Mr. THOMPSON. As you know, the law, Congressman, is that we have to have at least 10 and less than 50, and each region has got to have at least one State in it. I can—we are looking basically at somewhere in the area of 12 to 15 regions. That is what we are looking at, more on the lower side than the 50. We think it would be much more efficient and allow for——

Mr. RYAN. Did you say 12 to 50?

Mr. THOMPSON. The law says it has got to be between 10 to 50. We are looking at the lower end of it, because we think it would be better to have larger regions than smaller ones. We haven't made a final decision. We will keep you informed as a lot of people are concerned about this and interested.

In regards to the interest, everybody is really pretty excited about the law. There is just a lot of interest. Those people that have been in Medicare+Choice, I think you are going to see an expansion this year where we have seen nothing but declines in the past. We are down to 11.8 percent, 11.8 percent of the individuals in Medicare+Choice. We think that is going to grow. We are seeing a lot of individuals who have indicated that they are going to be reducing their premiums and increasing their benefits in order to grow their share.

So, it looks very, very promising. I think our actuaries think that within 10 years that one-third of the individuals will be in Medicare advantage programs, or PPOs.

Mr. RYAN. I think that is so important. Of all of the things and the responsibilities that you have ahead of you, this is a huge responsibility. When folks come to you and say we wish we had access in Medicare to plans just like you as a Federal employee and Members of Congress have, this is what it is. These Medicare advantage plans give seniors access to the same kinds of plans that we as Members of Congress and Federal workers have for themselves and their families.

So, I am just excited about the fact that seniors have a few choices available to them that are comprehensive. I am just eagerly awaiting the rollout of these plans. As soon as you have those details, we would really like to take a look at these.

Mr. THOMPSON. Thank you. Thank you for your leadership in the State in regards to this. Appreciate it.

Mr. MCCRERY. Mr. Shaw.

Mr. SHAW. Thank you. Mr. Secretary, it is also a delight to see you. You are one of my heroes in the Administration. Every time I see you, I think back to 1996 when we were able to form a partnership, you as a Governor and me as the Chairman of the Subcommittee on Human Resources to, really on a rescue mission, to take so many people out of poverty.

Back then it was predicted by the opponents of the welfare reform bill that we were going to throw a million kids into poverty. There were comments made in this Committee room and on the House floor that people are going to be sleeping on grates and how horrible it was going to be.

Quite the contrary has happened. We have taken 2 million kids out of poverty. We have cut the welfare rolls by 50 percent. We have maintained level spending on TANF in order to get to the hardest to help and the hardest to get out of poverty. Do you think the $17 billion, and I believe that figure is correct, correct me if I'm wrong but——

Mr. THOMPSON. It is $16.5 billion.

Mr. SHAW. Do you think that is sufficient?

Mr. THOMPSON. Absolutely. When you have got half of the population of the—they are going to be harder to place, but each individual applicant is going to have $7,000, closer to $16,000 behind them in order to get that individual placed.

We think the increased money that this House, you have supported an additional billion dollars, is going to be good for child care. So, we think it is a very good proposition that you sent over there. We think it is going to be very good.

All I can say in completing my answer to you is that we would not be here if it would not have been for your leadership, Clay. I thank you very much. You were outstanding. You were steadfast. You took a lot of criticism, but you were resolute in your leadership, and I always appreciate that and thank you very much.

Mr. SHAW. You are very kind. I appreciate that, particularly coming from you. I want to switch into another area, this is a troubling area that I have jurisdiction over as Chairman of the Subcommittee on Social Security. This is something we have got to get on very quickly.

All kinds of stories are saying don't worry about it until 2040, but you and I both know that we are going to have to look, beginning in 10 to 12 years, are we going to look around and say where are we going to get the money to pay the benefits? We can't send Treasury bills to our seniors. So, I hope we can really get this up.

I know in an election year, such as that we are about to finish up, that it is going to be very difficult to get particularly bipartisan support. That was, you know it is, even though President Clinton vetoed that welfare reform bill two times, he did sign it on the

third time, we gave it bipartisan credibility, which was tremendously important.

I keep reaching out to try to pick up allies on the other side of the aisle in order to bring a welfare bill to the House floor. I know the President is committed to it, and I hope that we can get on this very quickly.

I want to, in the time I have here, your jurisdiction is so vast, 5 minutes isn't nearly enough, but I want to bring something to your attention, and also to my colleague, Nancy Johnson's attention, who is Chairman of the Subcommittee on Health.

Something that I ran into this weekend—perhaps you already know about it—but it actually, I think, proves that this discount card is going to work. I had a constituent at one of the meetings that I was holding down in Palm Beach County who has diabetes and high blood pressure. The amount of medication he was taking and his prescription was costing like $60. I will leave the drug store unnamed at this particular point.

Then he went to one of the discount places and found out that he could get the same medicine for $12. This means, and I think that we need to look into exactly what drug stores are charging, and what opportunities that patients have to shop around and look for the best deal. It is a marketplace that is going to save us on this. I think that is going to play very heavily into the workings of the 25 percent or the discount that we are hoping to get. That means that someone in the private sector can do that shopping for our seniors and get them the best deal possible.

Mr. THOMPSON. Absolutely. We are going to have on our 1–800–Medicare and our computers, that you are going to be able to call up and you are going to be able to find out and compare card to card as to say, Lipitor, which is a very popular drug for cholesterol.

Mr. SHAW. This is the one of the ones——

Mr. THOMPSON. You are going to be able to have some comparison shopping on your computer as to what card is giving you the best discount on Lipitor. You can bet your bottom dollar, once that happens, that there is going to be some other companies and other PBMs that are going to be cutting that to make sure that they get the market share.

You are going to see a ratcheting down of drugs when we roll out these cards. We are going to put some comparison shopping up on the board so that you can come up and get the information as a senior. If you don't have a computer which somebody says, well, they don't have a computer, you are going to put people in the community that is going to assist you in order to be able to find out the best card for you.

Mr. SHAW. That is great news. I think the marketplace is the best controller.

Mr. THOMPSON. The marketplace is going to drive down the price of drugs.

Mr. SHAW. Most people just go to the drug store and give them a prescription and come back and pick it up and never shop it.

Mr. THOMPSON. We are going to do the shopping.

Mr. SHAW. It is like going to the filling station with the lowest price posted.

Mr. THOMPSON. That is what we are going to do.

Mr. SHAW. Thank you.

Mr. THOMPSON. We found on comparison of nursing homes, we put the quality up there, and you can't believe how many seniors are checking in on the quality standards that we put up on nursing homes. That is driving quality improvements in the whole nursing home industry.

We are going to do that with hospitals, now with the card. You are going to find that the seniors are going to be looking to Medicare to get them the information to do the correct shopping for themselves.

Mr. SHAW. Good news. Thank you, Mr. Secretary.

Mr. MCCRERY. Ms. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman. Mr. Secretary, I am sorry my plane was so late that I missed your comments and most of the hearing. First of all, it is—I know there is this controversy about cost, but that goes back. I will look at what you said.

Mr. THOMPSON. I went over all of the cost.

Mrs. JOHNSON. I am sure that you did. That goes back to some differences in judgment. What is really exciting about this bill, that so far all of the news is very good.

As you mentioned, the advantage plans are pushing down premiums, increasing benefits. They are just going to take off. They are the first access seniors will have to disease management, because for the first time we mandated that they have to provide disease management. The discount and the number of companies going to want—having put in letters to say that they want to be part of the discount plan——

Mr. THOMPSON. There is 106.

Mrs. JOHNSON. One hundred six. That means that competition will be intense and the prices will be pushed down dramatically.

I just want to compliment you and your staff on implementing, to this point, the cancer care new system of payment. The speed with which they have implemented the new practice expense formula, the degree to which they have kept physicians informed, and the groups in Washington part of the conversation, has really alleviated a lot of the concern and fear. There are plans for a very open process during this year, really, going to help assure that cancer care treatment in communities will not be adversely affected by a more honest payment system.

While they implemented the statutory provisions in regard to practice expenses the next portion where we go through the coding system and make sure that the codes are updated for what is really a very different kind of delivery system than ordinary office practice, will be very important. It will be very important that they oversee that well. It will be very important that the cancer community be very involved in that, because that has to come out right so that 2005 and 2006 and the years thereafter will come out right.

I am very impressed with how well they have kept the community informed, and under rather adverse circumstances, because of the way the law—at the time in which the law was passed. So, I really commend them on their work with oncology at this point and look forward to working with them.

What I wanted to ask you is how are you coming on implementing the chronic care provisions? One of the most startling, and kind of outrageous failings of Medicare is that it doesn't provide seniors with chronic disease the kind of help and support they need to keep healthy, to improve their quality of their retirement years and to control Medicare costs.

In the very polarized debate that characterized the public discussion of this bill before the votes and for the most part immediately thereafter, this whole issue of quality care and the way this bill pushes forward a whole new era of quality care for seniors was lost.

Since these programs are at the heart of improving quality and also the responsible way to approach cost control, I thought it would be a good idea if you could update me and the Committee on, and the public on how you are coming with implementing the disease management programs under the new law?

Mr. THOMPSON. First, let me just quickly go through this chart with you. Do you have that chart?

Mrs. JOHNSON. I got the chart.

Mr. THOMPSON. A $100 million difference is mainly on people wanting more access. The first one, $47 billion is for individuals that are low-income, that are going to be partaking of the services more. That is the biggest difference. Over one-third of the difference is that more low-income Americans are going to come in and use the system. I think that is positive.

Mrs. JOHNSON. If you will let me interrupt for a minute. I think when people figure out how good this is for low-income, you may very well be right. When you look at how many people are eligible for Medicaid and don't do it, are eligible for Quimby, Slimby and simply don't do it, I think that is what affected our estimates. So, that is perfectly reasonable.

Mr. THOMPSON. The second part is, we think that 94 percent of the individuals are going to participate in it, whereas CBO thinks 87 percent. You know that is $32 billion. That is human nature. Who knows what is going to be there in 5 or 6 years? I think it is quite positive.

In regards to your prevention and chronic illness and disease management, let me thank you. To me, this is the most important part of the bill. You and I teamed up on this one. I happen to think, this happens to be yours and my baby. We are going to make it work. I happen to be more interested in making this thing work than anything else.

If there is one way to improve the quality of health in seniors, it is through first a baseline physical, that we got in, then to start managing their diseases after we find out how sick they are. To me it is the right thing to do. We are already starting soliciting comments. We are also going to hopefully have our first contract later on this year so that we can get started early next year.

I just think that first off, thank you. Second off, I can assure you that this is one thing I have a personal stake in, and I am going to make everything revolve around this particular proposition.

Mrs. JOHNSON. Thank you.

Mr. MCCRERY. Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman. I want to thank you, Mr. Secretary, for the tone in which you set at these hearings and recognizing that our goal has to be a bipartisan effort. Also to see whether or not we can reinstate the cooperation that we have always had on this Committee with the chief actuary. As you know, as independent as they are, it is necessary for the committees of jurisdiction to be able to communicate with them.

In the past this has not been so, and as you pointed out that many of the issues that we were concerned about was discussed in the conference, and without belaboring the point that still did not give us access. So, in the spirit of the cooperation in which this office was developed, I assume that we can depend, on your cooperation, to give the majority and the minority access to the chief actuary for purposes of formulating legislation.

Mr. THOMPSON. Congressman, absolutely. I think—I may have been derelict in allowing my administrator, Tom Scully, to have more control over it than I should have, but he did an excellent job. He is very intelligent. Maybe he micromanaged the actuaries and the actuary service too much. I can assure you that from now on, for the remaining days that I am Secretary, you will have as much access as you want to anybody or anything in the Department you want, and all you have to do is call me.

Mr. RANGEL. Thank you very much, Mr. Secretary.

Mr. MCCRERY. Mr. Secretary, thank you very much. You have been very generous with your time today and as usual, your responses to the Committee's inquiries have been forthright and very informative. We look forward to seeing you next time.

Mr. THOMPSON. Thank you.

[Whereupon, at 5:00 p.m., the hearing was adjourned.]

[Additional written questions submitted from Representative Portman to Mr. Thompson, and his responses follow:]

Question: Mr. Secretary, I was extremely pleased to see that the President's budget proposes to continue the Children's Hospitals GME (CHGME) program's full funding for FY05 at $303 million. That's a 29-percent increase since President Bush took office.

This is a program that our Chair, Nancy Johnson, sponsored and many of us enthusiastically support. The Department has done great work in implementing this discretionary grant program and the program greatly benefits children's hospitals like Cincinnati Children's Medical Center, which will receive more than $12 million this year under the CHGME.

As you know, the CHGME program is now located in the Health Resources and Services Administration—HRSA—under the Public Health Service and not in the jurisdiction of this Committee. But, it does use Medicare rules, particularly in determining the number of Full Time Equivalent residents the hospitals receive payment for. I understand that Children's Hospitals are happy with this arrangement. Otherwise, they would have no framework for the program, and it would have taken a long time to set up. Also this program was meant to provide "equity" in federal GME funding for the children's hospitals until any larger GME reform that could encompass them might be enacted. So, FTE residents should be counted the same way, by and large.

Many of the children's hospitals fill out full Medicare cost reports and are providing GME related data to both CMS and HRSA. Last year, HRSA began operating its own separate fiscal intermediary contract for the CHGME program.

I'm interested in learning more about how HRSA and CMS are able to coordinate information and expertise to enable the CHGME to run as efficiently as possible with the least possible duplication of data requirements with Medicare. For example, many of the children's hospitals have a signifi-

cant number of residents "rotating" through their facility from other teaching institutions, as well as the resident programs they sponsor. CMS, with its fiscal intermediaries, has data on these rotators through its resident tracking system to help assure that they are not counted more than once.

Are HRSA and its fiscal intermediary able to use the Medicare data system to avoid duplications, or does HRSA also have to collect data and develop its own system for children's hospitals?

I'm hoping that you can share with us your comments on how HRSA and CMS are working together on CHGME, whether HRSA is using the CMS fiscal intermediary (IRIS) resident information, and any other major issues that have arisen that might require our attention, since changes that we make in Medicare GME provisions can have implications for the children's hospitals GME program.

Answer: The Children's Hospitals Graduate Medical Education Payment Program (CHGME PP) established a comprehensive methodology for assessing the full-time equivalent (FTE) resident counts reported by eligible children's hospitals for purposes of CHGME payments. This work is being done under contract, and the HRSA's contractor for this work, Blue Cross and Blue Shield Association (BCBSA) located in Chicago, is also the principal contractor for similar auditing activities carried out by the Center of Medicare and Medicaid Services (CMS).

HRSA developed a methodology that parallels that of Medicare. As part of this assessment process, the CHGME fiscal intermediaries (FIs) conduct "duplicate checks" based on the data that is available for that area by using the Medicare data systems. If a resident is being claimed by another acute hospital (general or children) the resident is not counted, and the children's hospital is asked to resolve the duplication. There is no national database of all residents being claimed by teaching hospitals and there is generally a lag time before Medicare completes the audits of FTE residents being claimed by teaching hospitals. However, HRSA has instructed its fiscal intermediaries to use the current Medicare data system to avoid duplications of FTE resident counts. Furthermore, about ⅓ of children's teaching hospitals receiving CHGME payments never reported FTE resident counts to Medicare. In order to assist these hospitals, HRSA developed and distributed free software (IRIS) that helps children's hospitals with the FTE resident assessment process and allows the CHGME and the Medicare FIs to conduct the "duplication checks."

As part of its effort to minimize burden on the children's hospitals, CHGME FIs are instructed to obtain work-papers (or audit papers) from the Medicare FIs before requesting such papers from the children's hospitals. Furthermore, upon completion of an FTE resident assessment by the CHGME FI, copies of work-papers are sent to Medicare FIs in cases where the two FIs work for different organizations. BCBSA intervenes in cases where the CHGME and the Medicare FIs disagree in the audit findings and helps resolve any outstanding questions. These steps are designed to ensure that there is no duplication of efforts and that the hospitals are audited once to establish the FTE resident counts.

Question: I was very pleased with the President's budget proposal to continue to allow states to transfer up to 10 percent of their TANF funds to the social services block grant (SSBG). The ability to transfer these funds has allowed Ohio to provide a wider variety of services to families than would be allowed under the TANF program. The flexibility afforded by this transfer has been instrumental in the success of Ohio's welfare reform efforts by allowing us to more holistically meet the needs of the poor.

The 10 percent transfer annually provides millions of additional SSBG dollars in Ohio for domestic violence programs, child welfare, home-based services for disabled children and adults, adoption assistance and supports local food banks. This transfer is also vital to support the counties' local reform efforts and without this transferability many of our most successful prevention and retention programs would be lost.

Will the administration continue to support state's ability to transfer TANF funds into SSBG?

Answer: Yes. The President's welfare reauthorization plan, Working Toward Independence, proposed to permanently restore full 10% transfer authority to the Social Services Block Grant.

Question: As you know, the Education and Research Centers—ERCs—funded through the National Institute for Occupational Safety and Health provide the leadership in occupational medicine, environmental and industrial hygiene, safety engineering and occupational health nursing, as well

as continuing education and service to the community in all of these disciplines.

The University of Cincinnati ERC serves a region of the country that includes substantial employment in agricultural, manufacturing and service sectors, and a large population base that may be at risk during release of a hazardous material, either intentional or unintentional.

The region's extensive highway system and port facilities along the Ohio River increase these concerns. The ERC research conducted at the University of Cincinnati is valuable both to the region and the nation. Recent projects have included respiratory disease among employees exposed to metal working fluids, better understanding of injury during auto collisions, the influence of landscape and buildings in dispersion of hazardous materials spills, and identification of factors contributing to workplace violence.

In addition, NIOSH ERCs play a crucial role in preparing occupational safety and health professionals in the fight against terrorism. Even before the tragedy of September 11, ERC faculty and graduates have worked for several years with emergency response teams to minimize losses in the event of a disaster. Some participated directly in monitoring efforts at the disaster sites. These tragic events, and the new threats faced by emergency responders, mail handlers, and other workers, illustrate the great concern for workplace health and safety needed in the ongoing war on terror. The role of ERC research and training has now been expanded to include more attention to identifying and reducing vulnerabilities to terrorist attacks. So, I believe the need for the expertise of the graduates from this program yearly is growing dramatically, and I'm delighted that since President Bush took office, spending on ERCs has increased by about 11 percent.

As the workplace continues to become a critically important focus of homeland security, I would welcome your thoughts on the need to encourage more professional education in these areas.

Answer: Thank you for your concerns about worker safety and health and your recognition of the important role of the CDC's National Institute for Occupational Safety and Health and the NIOSH Education and Research Centers in protecting the workplace from both well-recognized hazards and new and emerging threats. NIOSH supports 16 ERCs at leading universities across the country—including the ERC you mention at the University of Cincinnati. The ERCs provide graduate and continuing education programs in core occupational safety and health disciplines such as occupational medicine, occupational health nursing, industrial hygiene, safety, and related fields such as occupational epidemiology and injury prevention. ERCs are important regional resources for those involved with occupational safety and health, including industry, labor, government, academia, and the general public. They prepare practitioners, specialists, and research scientists to meet critical regional workforce needs and to conduct needed research to improve the safety and health of working Americans.

We recognize and appreciate the important work of NIOSH and its ERCs in addressing the challenges of the changing workforce, strengthening the base of health and scientific researchers and practitioners qualified to help protect and promote worker health, and expanding capacity to address terrorism, emergency preparedness and response, and related homeland security issues in the workplace. We will continue to support and encourage the valuable role of NIOSH and these key centers of excellence in these important new areas.

[Submissions for the record follow:]

Statement of National Association of Chain Drug Stores, Alexandria, Virginia

Mr. Chairman and Members of the Subcommittee. The National Association of Chain Drug Stores (NACDS) is pleased to submit this statement for the record regarding our priorities for programs under the direction of the Department of Health and Human Services (HHS), as reflected in the President's proposed Federal Fiscal Year 2005 budget submission. Some of these priorities are directly related to budget matters, while others reflect program implementation and operational concerns. We look forward to working with you and the Members of this Committee on these issues.

NACDS represents more than 200 companies that operate more than 35,000 community retail chain pharmacies. We employ more than 107,000 pharmacists and about 3 million total employees, and provide over 70 percent of all outpatient prescriptions in the United States.

Medicare

Medicare Prescription Drug Benefit Implementation: NACDS looks forward to working with the Congress and Administration on implementation of various provisions of the Medicare Modernization Act (MMA), P.L. 108–173. This will clearly be an enormous undertaking for the Administration in a rather short time frame, and we are already interacting with staff of the Centers for Medicare and Medicaid Services (CMS) on such issues as implementation of the discount card program and the Part D prescription drug coverage program which begins in 2006.

Among our highest priorities for the Part D coverage program are assuring that the pharmacy access standards included in the Part D section of the bill are implemented consistent with Congressional intent. This refers to the so-called "TRICARE access" standards. We are concerned that CMS's implementation of these standards in the Medicare-endorsed prescription drug discount card and transitional assistance program is inconsistent with Congressional intent. As a result, beneficiaries' access to their local community retail pharmacy will be reduced. As we understand it, CMS is allowing endorsed card sponsors to implement these standards on average across an entire service area, rather than in each state in the service area. We are particularly concerned about the impact of this interpretation on beneficiaries in rural areas, who might have to travel much longer distances to a pharmacy if the one closest to their home is not in the pharmacy network. These shortcomings should be corrected before the Part D coverage program is implemented, which is scheduled for 2006.

We will also work closely with CMS and Members of Congress to assure that beneficiaries are able to obtain covered Part D services—covered prescription drugs and medication therapy management services—from their pharmacy provider of choice. That is, we believe that the law requires plan sponsors to allow beneficiaries to obtain the same amount, scope, and duration of services from retail pharmacies as mail order pharmacies, whether the pharmacy is part of the network or not. We believe that it was clearly the intent of Congress to create as level a playing field as possible between retail and mail order pharmacies, and that the entities that are administering the Part D prescription drug coverage programs should do all they can to make any cost differences between mail order and retail pharmacy minimal for the beneficiary. In fact, in a colloquy between Senator Enzi, the provision's sponsor, and Senate Finance Chairman Grassley, it is clear from Senator's Grassley statements that:

> "*Medicare drug plans and Medicare Advantage organizations should not force seniors or the disabled to choose a mail order house when they would prefer to patronize their local community pharmacy . . . it is my expectation that any differential in charge be reasonable and based on the actual cost of providing the service in or through the setting in which it is provided.*" [1]

Finally, we are concerned about the structure and payment rates for drugs and pharmacy services that will be established for Medicare prescription drug "fall back" plans. These plans will exist in areas of regions where there are no risk-based Part D prescription drug plans. We want to be sure that pharmacies are paid adequately for providing pharmaceuticals and pharmacy services under these plans, and that payment rates are structured so that generic drugs are encouraged when they are the most cost-effective and therapeutically appropriate.

Medicare Part B Covered Drugs Supplying Fee: The interim final rule for the new Part B covered drug payment rates—published on January 7th by CMS [2]—fails to provide for a statutorily-mandated pharmacy supplying fee for certain Part B covered drugs. In its interim final rule, CMS indicates that it will not pay a separate Medicare Part B pharmacy supplying fee for 2004, but will rather "bundle" that payment with payment for the drug.

We believe that this effectively ignores the statutory requirement to establish a pharmacy supplying fee. Establishing a pharmacy supplying fee was consistent with the entire approach taken by this program reform, which was to more accurately

[1] Congressional Record, Senate, November 24, 2003, p. S15744.

[2] Medicare Program; Changes to Medicare Payment for Drugs and Physician Fee Schedule Payments for Calendar Year 2004; Interim Final Rule, CMS–1372–IFC, January 7, 2004.

pay for the cost of acquiring drug products, but also more accurately reflect the cost of safely delivering the product to patients. We believe that the pharmacy supplying fee is essential to this "logic." We urge CMS to publish a final rule quickly that would provide this supplying fee for this year, as well as future years.

We are also concerned about future changes in reimbursement to the Medicare Part B program that would tie pharmacy level reimbursement to manufacturers' level pricing metrics—such as average sales price (ASP) or average manufacturers' price (AMP). Even with some percentage markups, these metrics do not reflect the additional costs added to the cost of the drug product as it moves from the manufacturers' level to the community pharmacy level. In addition, their use is not appropriate in a real-time environment in which manufacturers' prices are changing constantly, since ASP and AMP rely on data that are generally several months outdated. They can also discourage generic usage, since they do not allow for sufficient incentive to encourage the dispensing of generics.

Pharmaceutical Transition Commission: It is important to create a seamless transition to the new Part D prescription drug benefit for Medicare beneficiaries who currently have outpatient prescription drug coverage—whether it is from state pharmaceutical assistance programs, Medicaid, or employer-based coverage.

For that reason, we strongly support the establishment of the State Pharmaceutical Transition Commission established under the MMA, and request that representatives of the community chain pharmacy industry be appointed to the Commission. Our industry has significant experience with existing sources of prescription drug coverage for Medicare beneficiaries, and will be the focal point for helping seniors coordinate their various prescription drug benefit programs. Among other items which we believe the Commission should address, requirements to obtain and provide information to pharmacies about other sources of beneficiary coverage should be placed on the Part D plans, not the pharmacies.

Billing for Supplies Using a Real-Time Standard: NACDS urges CMS to assure that upcoming modifications to HIPAA transaction billing standards assure that retail pharmacies and other components in the prescription drug distribution and billing system (i.e. PBMs, insurers, health plans, etc.) are able to adjudicate claims for prescribed supplies in the NCPDP 5.1 real time transaction standard and, not exclusively using a batch standard.

Both the discount card program and the Part D coverage program must provide a prescription drug benefit (which may include some covered supplies, such as insulin syringes) in a real time manner. Using batch standards to process any part of these claims will cause delay for the beneficiary in receiving their supplies and significant administrative complexities for the pharmacy provider in filling prescriptions for a beneficiary.

Medicaid

Medicaid Reimbursement: State Medicaid programs continue to face unprecedented challenges in balancing their budgets. However, many states are proposing draconian reductions in pharmacy reimbursement that we believe will severely jeopardize Medicaid recipient access to pharmacy services. Many of these reductions are being implemented without any justification or evidence that the rates are fair or adequate to maintain access to pharmacy services. For example:

- The state of California is proposing an arbitrary reduction of 10 percent off a Medi-Cal provider's total reimbursement rate.
- The state of New Mexico is proposing a significant decrease in a pharmacy's Medicaid dispensing fee from $3.65 to $1.50 for brand name prescriptions, and then a 3.5 percent reduction off the total reimbursement;
- The state of Alabama is proposing to decrease pharmacy reimbursement for dispensed drug products from AWP minus 10 percent to WAC plus 4 percent;
- The state of New Hampshire recently made an arbitrary determination that it would pay pharmacies AWP minus 16 percent plus $1.75 for each prescription.

These reductions are draconian and should not be approved by CMS. It costs pharmacies almost $8.00 to dispense the average prescription, but the cost of dispensing Medicaid prescriptions are higher. CMS must provide a "safety wall" for Medicaid recipients against these draconian cuts, which are arbitrary and being adopted simply for budgetary reasons.

In each case, the state has failed to both demonstrate why these reductions are justified, as well as perform the requisite analysis to show that access to pharmacy services is not jeopardized. We urge that these reductions be rejected by CMS. States can use other cost savings features that will get to the root of the case of

Medicaid prescription drug escalation, and produce more long-term reductions in Medicaid spending.

Uncollected Medicaid Prescription Co-payments (42 USC 1396(e) and 42 CFR 447.57(a)): In order to achieve cost-savings and control prescription drug utilization, many state Medicaid agencies are imposing and requiring pharmacies to collect co-payments on prescriptions dispensed to Medicaid recipients. Co-payments are in addition to any reimbursement a provider receives. By law, these prescription co-payments can range between 50 cents and $3 per prescription. A pharmacy cannot deny prescription drugs to Medicaid recipients if they are unable to pay the co-payment.

Moreover, federal regulation prohibits states from increasing payments to any provider to offset uncollected or uncollectible payments. This means that a pharmacy is required to absorb the uncollected co-payment. In some states, as many as half of all Medicaid prescription drug co-payments go unpaid. These uncollected co-payments essentially reduce pharmacy reimbursement to a level that may be well below the cost of providing the prescription to the patient. If patients are not obligated to pay the co-pay, there are serious questions about whether drug co-payments are effective in impacting drug utilization patterns.

If recipients don't have to pay co-pays, the co-payments serve only as a reduction of pharmacy reimbursement since Federal regulations prohibit states from compensating pharmacies for unpaid co-payments. NACDS asks that language be included in the FY 2005 Labor/HHS Appropriations bill that would repeal the Federal regulation that prohibits states from compensating Medicaid providers for uncollected cost sharing amounts.

Food and Drug Administration

Availability of Generic Drugs: NACDS supports increased funding for the FDA Office of Generic Drugs to speed approval of generic drugs to market, over and above that which has been proposed in the FY 2005 Budget submission. Many popular brand name medications will be losing patent protection, and it is important, consistent with the law, to make sure that these generic drugs are marketed as quickly as possible so that public and private payors, as well as cash-paying prescription consumers, can earn the benefits.

Assuring an Adequate Pharmacy Workforce

NACDS supports enactment of legislation that would establish permanent programs in the Public Health Service Act that would create specific grant and loan programs to encourage students to enroll in pharmacy schools, as well as encourage pharmacists to teach at schools and colleges of pharmacy. A chronic, nationwide shortage of pharmacists is hampering the ability of hospitals, nursing homes, and community pharmacies to provide important pharmaceutical care services. Numerous government and industry-sponsored studies have documented the pharmacist shortage, including a Congressionally-mandated report by the U.S. Health Resources and Services Administration (HRSA).

On November 25, 2003 ***The Pharmacy Education Act of 2003*** (S. 648), introduced by Senators Reed (D–RI) and Enzi (R–WY), passed the Senate. On November 21, 2003 Representatives Cubin (R–WY), John (D–LA), McGovern (D–MA), Pickering (R–MS), Rogers (R–MI), and Simpson (R–ID) introduced a companion bill in the house (HR 3591). Each bill authorizes funding for a program of educational loan repayments for pharmacy students and prospective pharmacy school faculty.

- NACDS conducted a survey of its members, which indicated that community pharmacies have almost 4,663 vacant pharmacist positions as of July 2003.
- Forty-six percent of the nation's hospitals are experiencing a shortage of pharmacists with an average pharmacist vacancy rate of 12.5%.[3]
- According to the General Accounting Office, "there is evidence of increasing demand for pharmacy services, which . . . is outpacing growth in supply."[4]
- A report by HRSA indicates that the pharmacist shortage is "a dynamic shortage" and concludes that "the factors causing the current shortage are of a na-

[3] Letter to Congress, American Hospital Association and the American Association of Colleges of Pharmacy, 6/5/02.

[4] "Supply of Selected Health Workers," GAO–02–137R, 10/10/01.

ture not likely to abate in the near future without fundamental changes in pharmacy practice and education."[5]

Now is the time for Congress to commit to assuring a long-term sustainable pharmacy workforce pool that will assure that medications are used appropriately and effectively in all populations, especially Medicare beneficiaries.

We very much appreciate the opportunity to provide our views on these important programs, and look forward to working with the Congress and the Administration on assuring that these programs remain sustainable and viable as we move forward.

Statement of Stephen A. Silverstein, and Mark C. Baff, Sandata Technologies, Inc., Port Washington, New York

Chairman Thomas, Ranking Member Rangel and distinguished Committee members:

We appreciate the opportunity to offer this statement on behalf of Sandata Technologies, Inc., a leading provider of advanced information technology solutions and services, in connection with the Committee's consideration of the Administration's proposed Fiscal Year (FY) 2005 Budget for the Department of Health and Human Services.

As you know, government-funded health care programs are under great pressure to deliver quality health care to eligible individuals while controlling overall expenditures. Recent estimates of the federal budget deficit, which is projected to exceed $520 billion in FY 2004, underscore the importance of these efforts. In response, policy-makers are rethinking ways to deliver quality services in a cost-efficient manner and to prevent the loss of limited health care dollars due to waste, fraud and abuse.

Improvements in health care information technology can play a critical role in accomplishing those objectives. Recognizing their potential, the Administration's proposed FY 2005 Budget targets additional federal funding to expand development and utilization of such technologies.

Specifically, it proposes $50 million in new funding "to support State or regional demonstration grants to test the feasibility of information exchange among health care settings and to fund other innovative information technology projects that improve health care quality." The Budget also proposes $50 million to fund grants through the Agency for Healthcare Research and Quality (AHRQ) "to continue efforts to promote, accelerate, and demonstrate the development and adoption of information technology, including in small and rural communities where health information technology penetration has been low."

In addition to financial resources, however, it is critical for the federal government to work in partnership with the private sector to identify and eliminate regulatory barriers that currently prevent the broader deployment of information technology. For example, many State Medicaid programs require handwritten signatures on paper documentation instead of accepting the electronic record and electronic signature. By contrast, Medicare accepts electronic records on a nationwide basis.

This example is particularly relevant, because health care is increasingly delivered in home- and community-based settings. Further, the Administration's FY 2005 Budget includes several proposals to expand home- and community-based care options for individuals with disabilities, including the Medicaid-financed "New Freedom Initiative" and "Money Follows the Individual" demonstrations.

To meet the growing needs of patients in these care settings, providers can rely on cost-efficient, proven information technology known as "telephony for home care." This technology allows providers to deploy a capable management infrastructure to reduce administrative costs and prevent waste or fraud, while ensuring that necessary services are delivered to achieve positive health outcomes for patients.

Telephony for home care ensures that patients receive the quality of care defined in their individual plan of care for the appropriate cost. It delivers important benefits to both payors and providers by reducing costs without cutting benefits to patients. For example, the City of New York's Medicaid-funded home care program is estimated to *save 5.5 percent of expenditures* from the difference between authorized hours and actual hours of service provided.

This service is available wherever telephone service is available, even under crisis conditions. During the 2003 blackout in the Northeastern United States, for example, the service continued to collect data to confirm that patients were being served.

[5] "*The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists*," Health Resources and Services Administration, Bureau of Health Professions, 12/00.

Given the distance involved in providing home- and community-based services to patient in rural areas, telephony is particularly effective as a management tool in those settings.

In addition, telephony can play an important role in addressing concerns identified by the General Accounting Office (GAO) in its June 2003 report regarding deficiencies in government oversight under Medicaid home- and community-based waivers. GAO noted that "[n]o nationwide data are available on states' quality assurance approaches or the status of quality of care for beneficiaries served by waivers for the elderly, but concerns have been identified about the quality of care provided under many of these waivers." With its accurate, real-time data collection capability, telephony can increase management visibility into field operations, track tasks accomplished and match them against the patient's plan of care, and provide a *comprehensive, permanent audit record*.

In the near term, federal health care programs will continue to face significant budgetary pressures. It is therefore essential to ensure that limited federal resources are targeted in the most cost-effective manner possible. Telephony for home care is a proven, reliable tool to advance that objective by reducing expenditures for government payors and providers *without* cutting benefits to patients.

Like many advancements in technology, however, broader utilization of telephony for home care has been impeded by outdated regulations. These include State Medicaid rules barring use of electronic records, as previously noted. Federal policies should remove these barriers by directing States to allow Medicaid-contracting providers to use telephony and other technologies to create and maintain electronic data records in lieu of paper records. The federal government should also provide grant funding to assist States in updating their health information technology systems.

We look forward to working in partnership with the Committee to accomplish the Administration's stated goal of working successfully "to advance the effort to translate information technology opportunities into higher quality, safer and more efficient health care for all Americans."

Thank you for your consideration of our views.