

**PRESIDENT'S FISCAL YEAR 2006 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 NINTH CONGRESS

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**PRESIDENT'S FISCAL YEAR 2006 BUDGET
FOR THE U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

THURSDAY, FEBRUARY 17, 2005

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

The Committee met, pursuant to notice, at 11:23 a.m., in room 1100, Longworth House Office Building, Hon. Bill M. Thomas (Chairman of the Committee) presiding.

[The advisory and revised advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 10, 2005
No. FC-3

CONTACT: (202) 225-1721

Thomas Announces Hearing on President's Fiscal Year 2006 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 2006 Budget for the U.S. Department of Health and Human Services. **The hearing will take place on Thursday, February 17, 2005, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the Honorable Michael Leavitt, 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 February 2, 2005, 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 7, 2005, in his Fiscal Year 2006 Budget, as submitted to the Congress. The budget for the U.S. Department of Health and Human Services 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 welfare reform programs.

In announcing the hearing, Chairman Thomas stated, "I look forward to working with Secretary Leavitt as we continue to implement the Medicare Modernization Act and continue to strengthen and modernize the program that is so vital to our Nation's seniors."

"This hearing also provides an opportunity to discuss the President's plan to improve on the 1996 landmark welfare reform law. Those reforms have led to higher earnings for low-income parents, historic declines in child poverty, and a sharp reduction in the welfare caseload. We have more work to do, and are committed to changes which will help move more individuals from welfare to work and independence."

FOCUS OF THE HEARING:

The focus of the hearing is to review the President's Fiscal Year 2006 Budget proposals for the U.S. Department of Health and Human Services.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "109th Congress" from the menu entitled,

“Hearing Archives” (<http://waysandmeans.house.gov/Hearings.asp?congress=17>). Select the hearing for which you would like to submit, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the on-line instructions, completing all informational forms and clicking “submit” on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, March 3, 2005. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item 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 submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies 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 submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission 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.

* * * **NOTICE—CHANGE IN TIME** * * *

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 16, 2005
FC-3-Revised

CONTACT: (202) 225-1721

Change in Time for Committee Hearing on President's Fiscal Year 2006 Budget for the U.S. Department of Health and Human Services

Congressman Bill Thomas (R-CA), Chairman, Committee on Ways and Means, today announced that the full Committee hearing on the President's Fiscal Year 2006 Budget for the U.S. Department of Health and Human Services previously scheduled for Thursday, February 17, 2005, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will now be held at 11:00 a.m.**

All other details for the hearing remain the same. (See full Committee Advisory No. FC-3 dated February 10, 2005.)

Chairman THOMAS. As I mentioned earlier, we welcome for the first time the new Secretary of the U.S. Department of Health and Human Services, and the Chair is pleased to indicate that Secretary Leavitt in a previous life was a Governor. The Chair believes that the most recent Secretary, also, a former Governor, provided enormous insight, support, and assistance in dealing with one of the major health programs that the United States has, which is coordinated closely with States, and that is the Medicaid program. That is not a subject matter within the jurisdiction of this Committee, but because those measures are so closely linked to the Committee's jurisdictional concerns over Medicare, that having someone who has been there and done that I think is an enormous advantage for us not to make some of the mistakes that had been made in the past, not through any concern or direction but simply because of a failure either of communication or understanding.

The President's fiscal year 2006 budget outlines a number of priorities to create incentives to reduce health costs, cover more of the uninsured with affordable health insurance, and make changes in the Medicare program. During the President's first term, of course, concrete steps were taken to advance those goals. A new Medicare prescription drug benefit, additional preventive and wellness benefits will provide seniors with the beginning of a 21st-century health care product. In addition, a new vehicle, Health Savings Accounts, which is designed to offer families broader access to affordable coverage, has been placed in law as well. We know much work needs to be done. This will be the beginning of a process, working closely with the administration in overseeing a number of areas, that requires continued administrative adjustment and attention with the scope of the new legislation. Mr. Secretary, I want to thank you for coming today. We are very interested in hearing your perspective on the President's budget and how to go forward.

The Chair will shortly recognize the gentleman from California, Mr. Stark, for the minority's opening statement. The Chair would acknowledge that the gentleman from New York, Mr. Rangel, is not able to be with us today because he has the privilege and honor of recognizing a monument to his predecessor, the first black representative from the eastern seaboard since reconstruction, Adam Clayton Powell, Jr. That event is occurring as we speak in New York. He had a choice to make, and the Chair believes he made the

correct one. So, the Chair will recognize the gentleman from California.

Mr. STARK. Thank you, Mr. Chairman; and welcome, Secretary Leavitt, to the Ways and Means Committee. We look forward to working with you the next few years. Your record precedes you. You did some innovative things as Governor of Utah, and we will be interested in seeing how that experience serves you here in Washington. Our own Governor is here, importuning us all for more money. I don't think he is going to be very successful, but that is the Republicans' fault. They are in charge, and they don't want to help a Republican Governor. Well, I don't know. I can't help them. We do face unprecedented cuts in Medicaid. The President's budget cuts some \$50 billion in funding to the State of California, and I am sure each of us here have similar problems in our own State. We are here, you are here as Secretary of Health and Human Services, so, let us get on to that.

There is a moral issue in a budget. When resources are limited, there is a need to rearrange spending and ensure that the most vulnerable are taken care of. For those who read the Bible, I think they could find for me where it says somewhere in the Bible that we should care for the least among us. Having said that, I would hate to be touting the President's budget when I arrive at the pearly gates, but that is another issue. The budget is notable not only for omissions but again for gimmicks. We have all heard the story of the changing prices of the drug benefit that we passed last year and how its costs have zoomed, at least insofar as the public knows. Many of us were not surprised that it went from whatever it was, 400 to 800, but the 400 to 537 could elicit an "I told you so."

In your budget—and you didn't write it. You weren't here when this document was created. We just found out last night that there is an \$8.3 billion cost increase in your budget that was not pointed out. We had to find it on a line item, and I gather that your office isn't going to make it public until Friday. It postpones risk adjustment for the managed care plans. We—at last year's budget, that was supposed to be implemented this year. Now you kick it out 4 or 5 years. We lose 8.5—almost \$8.5 billion, which is another giveaway to the managed care plans which are already costing us 115 percent of what standard Medicare costs us. It is that kind of shell game where things are hidden from us and/or postponed in their announcements that make the public hearken back to weapons of mass destruction and changes in estimates on the costs of drug—of a drug plan, and I don't think it serves any of us well. We can blame the shenanigans on the Republicans, but it ends up they get blamed by the public just as much as the rest of us for not giving us the true story.

Your budget also, confirms that there are no savings from the Medicare Advantage Plan, and in fact they cost more than traditional Medicare. Now I am willing to bet you—I am not much of a betting man, but I will bet you a thousand bucks to the charity of your choice, if you will award me the same opportunity, that there are never any savings, whether you take it over the budget window or over the infinite horizon, from the Medicare Advantage Plan. Your own actuaries, I might suggest, have already confirmed

that, if you want to turn behind you. So, I don't think you can find in HHS or the administration an actuary or an estimator who will tell you that these managed—these Medicare Advantage Plans do anything but cost the taxpayers more. Now some might say there are more benefits for seniors, but those benefits ought to go to every Medicare beneficiary and not just those as an inducement to try and dismantle Medicare as we know it. We are going to talk about TANF later; and I know, based on your record, that you believe we can do better there.

Then we will probably mention the negotiation on drug prices. Your predecessor said he should have been allowed or your office should have been allowed to continue the negotiations. It just seems a bewilderment to me that we are willing to hamstring you and not allow you, if you found a way to negotiate better prices for our seniors under the Medicare drug benefit, to do so. To me, that is a blatant gift to the pharmaceutical industry and is an irresponsible way for us to manage the taxpayers' money. So, we are going to have a lot to work on. My colleagues are going to have a lot of interest in your ideas for going forth as you administer perhaps the largest bureaucracy and I think one of the most important in our government. Thank you for joining us today.

Chairman THOMAS. I thank the gentleman. I will tell the Secretary that any written statement he may have will be made a part of the record, and he can address the Committee in any way he sees fit. Mr. Secretary.

STATEMENT OF THE HONORABLE MICHAEL LEAVITT, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary LEAVITT. Good morning, Mr. Chairman. Thank you. Congressman Stark, thank you. Members of the Committee, I want to express appreciation for having an opportunity to come and to discuss the President's fiscal year 2006 budget. The President and I share what I believe to be an aggressive agenda for the upcoming year. The agenda takes us closer to a Nation where health insurance is within reach of every American, where we become a nation with American workers who are competitive and have a comparative advantage in a global marketplace because of the fact that they are healthy and productive, a nation where health technology and information technology improve and produce fewer mistakes and produce better outcomes and lower costs.

To advance that agenda, the President proposes a \$642 billion budget. That is an increase of \$58 billion. It is an increase of 10 percent over the previous year. The discretionary portion of that budget is \$67 billion in budget and authority and \$71 billion on the program level. Now \$642 billion is a lot of money, and it is my responsibility as Secretary to ensure that all of those dollars are spent effectively. The people of this country who pay the taxes and the people who are served by them should expect no less.

I would like to just take a moment or two and outline some of the highlights, some you have mentioned. Medicaid, a health insurance program for nearly 46 million Americans. State governments are struggling, frankly, under the burdensome rules and the burdensome regulations and the financing system that exists between

the Federal government and their own States. The President and the Department are committed to resolving the growing challenges that they have. These are challenges that we share. This is a partnership. The President's budget would assure appropriate and economically responsible changes. As the President's budget notes, taxpayers will save \$60 billion over the next 10 years when inappropriate Federal spending, such as intergovernmental transfers and other loopholes are eliminated.

If these savings are enacted, State and Federal taxpayers will save substantially on a \$5 trillion budget on Medicaid over the next 10 years. That budget will continue to grow as one of the fastest-growing segments of the Federal budget. It will grow at more than 7 percent a year for those entire 10 years. When spending on our most needy populations to ensure the effective use of tax dollars, we propose to build on the successes of the SCHIP program, the State Children's Health Insurance Program, and waiver programs. These allow States the flexibility to construct targeted benefits, to coordinate with private insurance, and to extend coverage to uninsured individuals and to families not typically covered by Medicaid.

This is just part of the President's plan. It is a plan to help some of the 45 million Americans who currently don't have health insurance. In addition to our efforts to improve Medicaid and SCHIP, we propose to spend \$125.7 billion over the next 10 years to expand health coverage to millions of Americans. We are working to help Americans through tax credits, through purchasing pools, through Health Savings Accounts. We expect 12 to 14 million additional people to gain health insurance over the next 10 years as a result of those efforts. We also request \$2 billion, a \$304 million increase over 2005, to fund community health centers. This will help us complete the President's commitment to create 1,200 new and expanded sites to serve an additional 6.1 million people by 2006. We also work to help needy children and families. We are committed to building upon the success of the 1996 reforms that gave people the resources they needed to move from dependence on a welfare check to independence in a paycheck.

This Committee played a key role in the reauthorizing of TANF and in establishing it in the first place and reauthorizing it. I want to express my appreciation as a Governor at the time and now as Secretary, I look forward to working with you to reauthorize this very important program, and we hope to do it this year. All of these efforts seek basic reforms in the health system, and they will help us move toward a more personalized patient-centered medicine. To that end, the President's budget proposes an investment of \$125 million to make electronic health records a reality. Another challenge I look forward to is the successful implementation of the Medicare Modernization Act, the prescription drug benefit, and the Medicare advantage regional plans in 2006. With MMA, we are helping seniors save money, improving preventative care, and increasing access to doctors and medical care. Between now and January 1 of 2006, we have a lot of work to do, and I want to give you my commitment that we will not fail.

I know there was a great deal of discussion over the past week about the cost of the new Medicare drug benefit, and I would like to address briefly that issue today. Recent press reports have inac-

curately claimed that our cost estimates have dramatically increased. This is simply not true. The main reason that the 2006 budget shows a higher cost for Medicare than the 2005 budget is that they reflect different windows. Last year's projection of the 2004 to 2013 looked at a period with 8 years of prescription drug benefit. This year's projection of 2006 through 2015 includes 10 years of that benefit. We shouldn't be surprised that we see a different part of the landscape when we look out a different part of the window.

Now some have asserted that the estimate on MMA is now over \$1 trillion. Again, I just want to emphasize this is not true. The trillion dollar figure is an estimate of the gross. To arrive at the actual estimate, the net estimate, you subtract out hundreds of billions of dollars of Federal revenue, such as beneficiary premiums and State payments. Focusing exclusively on the gross spending levels without considering the offset savings creates false impressions and does a disservice to the budget process as well as Medicare beneficiaries. In a little more than 10 months, almost 43 million Americans will be eligible to receive this much-needed assistance with the high cost of prescription drugs. So, I propose today, Mr. Chairman, that we put aside differences, and work together toward the goal of ensuring that seniors and people with disabilities, successfully sign up for these new benefits. We owe it to them.

We also, work to protect the homeland. One of the areas that we have made our greatest achievements in and one of the areas we face our greatest challenges is in strengthening our public health infrastructure. Our proposed budget requests \$4.3 billion to continue this work. It is an increase of nearly 1,500 percent over 2001. Including the 2006 budget request, we will have spent or requested nearly \$19 billion since September 11, 2001, and that investment is beginning to show tangible results. To support HHS's responsibility to lead public health and medical services during major disasters and emergencies, we are also, requesting \$1.3 billion to support work at CDC and at the Health Resources and Services Administration to improve State and local health centers and hospitals with their preparedness.

We are also, requesting \$600 million to strengthen the national strategic stockpile, which would provide Americans with almost immediate access to needed medicines in the event of a major health emergency and to ensure that drugs and medical devices that Americans routinely use are both safe and effective and that they get to the market as quickly as possible. The budget includes requests for \$1.9 billion for the FDA. That is an increase of \$81 million over 2005. This would also, help us to combat threats to our food supply, improve our means of detecting contaminated food, and increase our search in ways to increase our food security.

On Tuesday, I announced the creation of a Drug Safety Oversight Board to review the safety and the effectiveness of some of the drugs that may need further monitoring after they go to market and are in use. Because the foundations of society rest upon healthy moral values, the President has proposed \$206 million to support abstinence education programs. The 2006 budget expands activities to educate adolescents and their parents about the risks associated with early sexual activity and to provide them with the

tools they need to help make healthy choices as young people. We are also, requesting \$150 million to help us assist victims of drug abuse through access recovery initiatives.

In conclusion, this is a strong, fiscally responsible budget at a challenging time in the Federal government, and we need to further strengthen the economy and continue to protect the homeland. We look forward to working with Congress and this Committee and the medical community and all Americans as we implement the new Medicare law and we carry out initiatives that President Bush has put forward to propose a healthier, a safer, and a stronger America. Mr. Chairman, thank you.

[The prepared statement of Secretary Leavitt follows:]

Statement of The Honorable Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services

Good morning Chairman Thomas, Congressman Rangel, and members of the committee. I am honored to be here today to present to you the President's FY 2006 budget for the Department of Health and Human Services (HHS). The President and I share an aggressive agenda for the upcoming fiscal year, in which HHS advances a healthier, stronger America while upholding fiscal responsibility and good stewardship of the People's money.

In his February 2nd State of the Union Address, the President underscored the need to restrain spending in order to sustain our economic prosperity. As part of this restraint, it is important that total discretionary and non-security spending be held to levels proposed in the FY 2006 budget. The budget savings and reforms in the budget are important components of achieving the President's goal of cutting the budget deficit in half by 2009 and I urge the Congress to support these reforms. The FY 2006 budget includes more than 150 reductions, reforms, and terminations in non-defense discretionary programs, of which 19 affect HHS programs. The Department wants to work with the Congress to achieve these savings.

The President's health agenda leads us towards a nation of healthier Americans, where health insurance is within the reach of every American, where American workers have a comparative advantage in the global economy because they are healthy and productive, and where health technology allows for a better health care system that produces fewer mistakes and better outcomes at lower costs. The FY 2006 HHS budget advances this agenda.

The FY 2006 HHS budget funds the transition towards a health care system where informed consumers will own their personal health records, their health savings accounts, and their health insurance. It enables seniors and people with disabilities to choose where they receive long-term care and from whom they receive it. Equally important, it builds on the Department's Strategic Plan and enables HHS to foster strong, sustained advances in the sciences underlying medicine, in public health, and in social services.

To support our goals, President Bush proposes outlays of \$642 billion for HHS, a 10 percent increase over FY 2005 spending, and more than a 50 percent increase over FY 2001 spending. The discretionary portion of the President's HHS budget totals \$67 billion in budget authority and \$71 billion in program level funding. In total, the HHS budget accounts for almost two-thirds of the proposed federal budget increase in FY 2006.

The Department will direct its resources and efforts in FY 2006 towards:

- Providing access to quality health care, including continued implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;
- Enhancing public health and protecting America;
- Supporting a compassionate society; and
- Improving HHS management, including continuing to implement the President's Management Agenda

Americans enjoy the finest health care in the world. This year's budget provides opportunities to make quality health care more affordable and accessible to millions more Americans.

Medicare

HHS will be working in FY 2006 to successfully implement the Medicare Modernization Act (MMA), including the Medicare Prescription Drug Benefit and the

new Medicare Advantage regional health plans. I know there has been a lot of discussion over the past week about the cost of the new Medicare proposal, and I want to address that issue today. Recent press reports have inaccurately claimed that our cost estimates have dramatically increased. This is simply untrue.

The passage of time is the main reason that the FY 2006 budget shows a higher net federal cost (\$723.8 billion) for 2006–2015 than the cost estimate for 2004–2013. In the original cost estimates, the first two years in the ten-year budget window were for years before the new drug benefit was implemented (2004 and 2005). The ten-year budget window reflected in the 2006 budget includes ten full years of actual drug benefit spending. In effect, the passage of time has dropped two low-cost dollar year estimates (only transitional assistance spending) from the budget window and added two high-cost years, due to anticipated increases in average drug spending and the growth of the Medicare population. People should not be surprised that the numbers look different as a result of the advance of time.

Some individuals have asserted that the estimate for MMA implementation is now over a trillion dollars. This assertion is completely unsupported by facts. The trillion dollar figure is a gross estimate that neglects to subtract out hundreds of billions of dollars of federal revenue, including beneficiary premiums, state payments, and other offsetting federal savings. Focusing exclusively on gross spending levels without considering the offsetting savings creates false impressions and does a disservice to the budget process and to Medicare beneficiaries.

Moving beyond the subject of funding, I hope we can all begin to focus on the task at hand—ensuring successful implementation of a strengthened and improved Medicare program with the new prescription drug benefit. Between now and January 1, 2006, we have a lot of work to do, and I give you my commitment that we will not fail. I know not everyone in this committee supported the passage of the Medicare bill, but it is now law, and in 10 ½ months, almost 43 million Americans will be eligible to receive much needed assistance with the high cost of prescription drugs. Let us put aside our differences and work together towards the goal of ensuring that seniors and people with disabilities are successfully sign up for their new benefits. We all owe that to them.

Uninsured

In FY 2006, the President also proposes steps to promote affordable health care for the approximately 45 million Americans who are currently uninsured. The President proposes to spend more than \$125.7 billion over ten years to expand insurance coverage to millions of Americans through tax credits, purchasing pools, and Health Savings Accounts. To improve access to care for many uninsured Americans, the President's budget requests \$2 billion, a \$304 million increase from FY 2005, to fund community health centers. This request does two things. It completes the President's commitment to create 1,200 new or expanded sites to serve an additional 6.1 million people by 2006. By the end of FY 2006, the Health Centers program will deliver high quality, affordable health care to over 16 million patients at more than 4,000 sites across the country. In 2006, health centers will serve an estimated 16 percent of the Nation's population who are at or below 200 percent of the Federal poverty level. Forty percent of health center patients have no health insurance and 64 percent are racial or ethnic minorities. In addition, the President has established a new goal of helping every poor county in America that lacks a community health center and can support one. The budget begins that effort by supporting 40 new health centers in high poverty counties.

Moreover, the President proposes a budget that would expand access to American Indian and Alaska Native health care facilities, staff six newly built facilities to serve the growing eligible population of federally recognized members of Native American Tribes, and address the rising costs of delivering care. In FY 2006, the Indian Health Service will provide quality health care through 49 hospitals, more than 240 outpatient centers, and more than 300 health stations and Alaska village clinics. In total, the President proposes increasing health support of federally recognized tribes by \$72 million in FY 2006, for a total of \$3.8 billion.

The President and the Department are also committed to resolving the growing challenges facing Medicaid. Medicaid provides health insurance for more than 46 million Americans, but as you are all aware, States still complain about overly burdensome rules and regulations, and the State-Federal financing system remains prone to abuse. This past year, for the first time ever, states spent more on Medicaid than they spent on education. Over the next ten years, American taxpayers will spend nearly \$5 trillion dollars on Medicaid in combined state and Federal spending. The Department proposes to make sure tax dollars are used more efficiently by building on the success of the State Children's Health Insurance Program (SCHIP) and waiver programs that allow states the flexibility to construct targeted

benefit packages, coordinate with private insurance, and extend coverage to uninsured individuals and families not typically covered by Medicaid.

The President proposes to give states more flexibility in the Medicaid program in order to enable states to increase coverage using the same Federal dollars. The tools we have at our disposal today were not available when Medicaid was created. States largely agree that current Medicaid rules and regulations are barriers to effective and efficient management. Over the past ten years, Medicaid spending doubled. At its current rate of growth (7.4%), the Federal share of Medicaid spending would double again in another ten years.

The growth in Medicaid spending is unsustainable. I intend to enter into a serious discussion with Governors and Congress to decide the best way to provide states the flexibility they need to better meet the health care needs of their citizens.

The President plans to expand coverage for the key populations served in Medicaid and SCHIP by spending \$15.5 billion on targeted activities over ten years. The Budget includes several proposals to provide coverage, including the Cover the Kids' campaign to enroll more eligible uninsured children in Medicaid and SCHIP. In addition, the extension of the Qualified Individual (QI) and transitional medical assistance programs will ensure coverage is available to continue full payment (subject to a spending limit) of Medicare Part B premiums for qualified individuals, and provide coverage for families that lose eligibility for Medicaid due to earnings from employment. Also, community-based care options for people with disabilities will be expanded through the President's New Freedom Initiative, including authorizing \$1.75 billion over five years for the Money Follows the Person Rebalancing demonstration.

Overall, these efforts to expand health insurance coverage, as well as those in other Departments, work together to extend health care coverage and health care services to millions of people. Thanks to the comprehensive nature of this agenda, workers are already investing money tax-free for medical expenses through Health Savings Accounts, Americans have increasing flexibility to accumulate savings and to change jobs when they wish, and more Americans are accessing high-quality health care. We estimate that 8 to 10 million additional people will gain health insurance over the next ten years. Together, these efforts to expand insurance coverage and improve the Medicaid and SCHIP programs will cost approximately \$140 billion over the same period.

At the same time, we are taking steps to ensure states can use their Medicaid funds to the fullest potential to reach more individuals in need of health care. The budget includes proposals that will assure an appropriate partnership between the Federal and state governments. We would like to work cooperatively with the states to respond to the challenges in Medicaid. We must eliminate the vulnerabilities that threaten Medicaid's viability. In our budget, we have proposed a series of legislative changes that will ensure Medicaid dollars are used appropriately to fulfill the program's purpose to provide health care coverage for low income families and elderly and disabled individuals with low incomes. Under this proposal, inappropriate federal spending on Medicaid intergovernmental transfers and spending resulting from other current loopholes in Medicaid law will decrease by \$60 billion over 10 years.

As a former Governor, I understand the pressure on states in developing their budgets, particularly given the lack of flexibility in the current Medicaid law. However, some state officials have resorted to a variety of inappropriate loopholes and accounting gimmicks that shift their Medicaid costs to the taxpayers of other states. Obviously, states that are not engaging in these activities will not be affected by the proposals in the same manner as states that are. Collectively, the overall impact of the \$60 billion ten-year decrease in federal Medicaid spending on states will in reality be about \$40 billion, because by changing the calculation of prescription drug payments to be based on the average sales price and by tightening asset transfer rules, approximately \$20 billion in state spending will be saved. And it should be noted that two-thirds of the savings will occur beyond the initial five-year budget window.

Preparedness

The HHS FY 2006 budget will also build on the Department's achievements in strengthening our ability to detect, respond, treat, and prevent potential disease outbreaks due to bioterrorist acts.

It will enable the National Institutes of Health (NIH) to increase research efforts in developing bioterrorism countermeasures and to fund biomedical research at current levels, it will allow the Centers for Disease Control and Prevention (CDC) to expand the Strategic National Stockpile, and it will support the Food and Drug Administration's efforts to defend the nation's food supply. This proposal requests \$4.2 billion to continue this work, an increase of almost 1500% over 2001. This request

raises to \$19 billion the cumulative amount invested since September 11, 2001 on public health preparedness, and that investment is showing tangible results.

Let me mention just a few of the highlights and also note that HHS works in close cooperation with DHS on many of these activities, including the medical surge initiative and food node threats and vulnerability assessments:

- HHS has a responsibility to lead public health and medical services during major disasters and emergencies. To support this, we are requesting \$70 million for the Federal Mass Casualty Initiative to improve our medical surge capacity. We are also investing \$1.3 billion to support work at CDC and the Health Resources and Services Administration (HRSA) to improve state and local public health and hospital preparedness.
- In the event of a major health emergency, one posed by either nature or through the intentional use of a weapon of mass destruction, the Strategic National Stockpile would provide Americans with almost immediate access to an adequate supply of needed medicines. In order to ensure the effectiveness of the Stockpile, we're requesting \$600 million to buy additional medicines, replace old ones, provide specialized storage, and get any needed medicines and supplies to any location in the United States within 12 hours. \$50 million of this will go to procure portable mass casualty treatment units.
- We're requesting \$1.9 billion for the Food and Drug Administration (FDA)—an increase of \$81 million over 2005. \$30 million of this request would be directed to improving the agency's national network of food contamination analysis laboratories and to supporting vital research on technologies that could prevent threats to our food supply. HHS also proposes to dedicate \$6.5 million more than in FY 2005 to evaluating and communicating drug safety risks to the public and applying scientific expertise to explore the risks of medical products already on the market.

We now have a heightened awareness that the nation's critical food safety infrastructure must be better protected. FDA quickly learned that pursuing more field exams, alone, is not the most effective strategy for providing this protection. The new Prior Notice requirement on the shipment of foods allows FDA to conduct intensive security reviews on products that pose the greatest potential bioterrorism risk to consumers in the United States. We intend to compliment these inspection efforts with further improvements to the national network of food contamination analysis laboratories, and to provide support for vital research on technologies that could prevent threats to food supply. Investments like these will allow FDA to work smarter in the future.

The Food and Drug Administration is an integral component in our efforts to promote and protect the health of the United States public. Its mission is broad, and the agency's decisions affect virtually every American on a daily basis. In addition to food defense, the proposed \$81 million increase will be focused on achieving specific improvements in drug safety and medical devices.

The budget includes a total of \$747 million for human drugs and biologics, an increase of \$26 million. With these funds, we propose to strengthen FDA's Office of Drug Safety with an increase of \$6.5 million, for a total of \$33 million. This increase will better equip the Office to carry out Center-wide responsibilities for drug safety analysis and decision-making. Critical staff expertise will be augmented in such areas as risk management, communication and epidemiology. Increased access to a wide range of clinical, pharmacy and administrative databases to monitor adverse drug events will be obtained. Also, external experts will also be used to a greater degree to evaluate safety issues.

Medical device products regulated by FDA must be safe and effective. The budget requests \$289 million, an increase of \$12 million, to improve timely performance in the review of applications, as well as, maintaining consistent high standards of safety and quality. Additional funds will also be directed towards medical device post-market safety activities.

Vaccines

The FY 2006 budget also includes targeted efforts to ensure a stable supply of annual influenza vaccine, to develop the surge capacity that would be needed in a pandemic, to improve the response to emerging infectious diseases before they reach the United States, and to improve low-income children's access to routine immunizations.

HHS plans to invest \$439 million in targeted influenza activities in FY 2006, in addition to insurance reimbursement payments through Medicare. The budget includes a two-part \$70 million approach to ensure industry manufactures an adequate supply of annual influenza vaccine. The Vaccines for Children (VFC) program

will again set aside \$40 million in new resources to ensure an adequate supply of finished pediatric influenza vaccine. The discretionary Section 317 program will use \$30 million to get manufacturers to make additional bulk monovalent vaccine that can be turned into finished vaccine if other producers experience problems, or unusually high demand is anticipated.

To improve low-income children's access to routine immunizations, the budget includes legislative proposals in VFC that I believe should be strongly supported by the members of this Committee. This legislation would enable any child who is currently entitled to receive VFC vaccines to receive them at State and local public health clinics. There are hundreds of thousands of children who are entitled to VFC vaccines, but can receive them only at HRSA-funded health centers and other Federally Qualified Health Centers. When these children go to a State or local public health clinic, they are unable to receive vaccines through the VFC program. This legislation will expand access to routine immunizations by eliminating this barrier to coverage and will help States meet the rising costs of new and better vaccines. As modern technology and research has generated new and better vaccines, that cost has risen dramatically. For example, when the pneumococcal conjugate vaccine became available, it increased the cost of vaccines to fully-immunize a child by about 80 percent. FDA has recently approved a new meningococcal vaccine that will further raise the cost to fully-immunize a child—making this legislation even more important.

To improve our Nation's long-term preparedness, NIH will invest approximately \$119 million in influenza-related research—nearly six times the FY 2001 level. The budget also increases the Department's investment to develop the year-round domestic surge vaccine production capacity that would be needed in a pandemic, including new cell culture vaccine manufacturing processes, to \$120 million. These research and advanced development efforts will be complemented by expanding CDC's Global Disease Detection initiatives from \$22 million to \$34 million to improve our ability to prevent and control outbreaks before they reach the U.S.

WELFARE REFORM

It has been three years since President Bush first proposed his strategy for reauthorizing TANF and the other critical programs included in welfare reform. During this time, the issues have been debated thoroughly but the work has not been completed and States have been left to wonder how they should proceed. We believe it is extremely important to finish this work as soon as possible and set a strong, positive course for helping America's families.

Building on the successes of the 1996 law, President Bush laid out a clear path for the next phase of welfare reform. The proposal is guided by four critical goals that will transform the lives of low-income families: strengthen work, promote healthy families, give States greater flexibility, and demonstrate compassion to those in need. These are the guideposts that shaped the Administration's proposal for TANF, child support, child care and abstinence education. This framework has not changed.

In FY 2003, States reported that only 31 percent of families with an adult recipient participated in the required 30 hours of TANF work activities. We need to reverse this trend so that all TANF recipients are given the opportunity to become self-sufficient. States also have been less effective in placing clients with multiple barriers (such as mental health issues, addiction, learning disabilities, and limited English proficiency) in work. We need to ensure that these barriers are addressed and that every family is given work opportunities leading to self-sufficiency. But our efforts cannot stop there. We also need to develop more effective models of post-employment supports that lead to career development and wage progression, programs that sustain and keep families together, and programs that enable low-income, non-custodial fathers to help their families both financially and in non-financial ways.

In addition, given what the research literature tells us about the benefits healthy marriages confer on both children and adults, we need to promote policies that support the formation and stability of healthy marriage, and provide a strong and nurturing environment for raising children. The President's budget includes \$200 million annually to promote healthy marriage through demonstrations, research and a matching grant program. Further, the budget also requests \$40 million for the Promotion and Support of Responsible Fatherhood as mandatory funding.

The child support enforcement proposals being considered as part of welfare reform reauthorization build on our success by focusing on increasing child support collections and directing more of the support collected to families. This focus on families represents a major shift away from the historic purpose of the child support enforcement program which was heretofore aimed at recouping Federal and State welfare outlays. In addition, we request proposals originally offered in the FY 2005

budget aimed at improving and increasing the collection of medical child support, as well as several proposals to improve automation tools, strengthen existing enforcement tools, and assist families in gaining self-sufficiency. The totality of these proposals offer an impressive \$3.4 billion in increased collections to families for a net Federal cost of just \$52 million over five years.

The Administration remains committed to preserving the key aspects of the child care program: parental choice, administrative flexibility for States and Tribes, inclusion of faith-based and community-based organizations, and development of literacy, numeracy, and other early learning skills for children in care; while maintaining the underlying structure and financing of these essential child care programs.

Our proposal supports maintaining the historically high level of funding for child care, including \$2.1 billion for the Child Care and Development Block Grant and \$2.7 billion for Child Care Entitlement—a total of \$4.8 billion for what is referred to as the Child Care and Development Fund or CCDF. In addition, States continue to have the flexibility to use TANF funds for child care both by transferring up to 30 percent of TANF funds to CCDF, and by spending additional TANF money directly for child care. When TANF funds are considered, as well as Head Start and other State and Federal funding sources, over \$18 billion currently is available for child care and related services for children.

The final piece of our welfare reform strategy supports reauthorization of the State Abstinence Education Program. Expanding abstinence education programs is also part of a comprehensive and continuing effort of the Administration, because they help adolescents avoid behaviors that could jeopardize their futures. Last year, HHS integrated abstinence education activities with the youth development efforts at the Administration for Children and Families (ACF), by transferring the Community-Based Abstinence Education program and the Abstinence Education Grants to States to ACF. The FY 2006 budget expands activities to educate adolescents and parents about the health risks associated with early sexual activity and provide them with the tools needed to help adolescents make healthy choices. The programs focus on educating adolescents ages 12 through 18, and create a positive environment within communities to support adolescents' decisions to postpone sexual activity. A total of \$206 million, an increase of \$39 million, is requested for these activities.

CHILD WELFARE

The FY 2006 President's Budget includes three legislative proposals for Foster Care and related programs. First, the alternative funding proposal, which would allow states the option to receive their foster care funding as a flexible grant over five years to support a continuum of services to families in crisis and children at risk. This proposal will increase budget authority by \$36 million in FY 2006, and it is budget neutral over five years. The second proposal brings the Foster Care and Adoption Assistance matching rate for the District of Columbia in line with the District's matching rate in Medicaid and SCHIP. This would increase the Federal matching rate for the District from 50 percent to 70 percent. The cost in FY 2006 is \$8 and \$40 million over five years. The final proposal would clarify the process for determining Title IV-E eligibility in the program. On March 3, 2003, the Court of Appeals for the 9th Circuit held in *Rosales v. Thompson* that a child living with an interim caregiver may be eligible for Title IV-E foster care even though the child would not have been eligible in the home from which the child was legally removed. The Rosales decision contravenes the Department's long-standing interpretation of the Social Security Act that eligibility is based upon the home from which the child is removed, not the home of the interim caretaker. This proposal would amend the statute in accord with the Department's long-standing policy. It would save \$84 million in FY 2006 and \$399 million over five years.

The budget includes \$1.8 billion for the Adoption Assistance program, which supports families that adopt special-needs children. This is an increase of \$26.9 million over the FY 2005 request. This level of funding will support approximately 369,500 children each month. States will use these funds to provide maintenance payments to adoptive families, absorb administrative costs associated with placing a child in an adoptive home, and provide training for professionals and adoptive parents.

The budget also includes a continuation of \$140 million for the Independent Living program to fund a variety of services to ease the transition from foster care for youth who will likely remain in foster care until they turn 18 and former foster children between the ages of 18 and 21. And, the budget includes \$305 million in mandatory funds under the Promoting Safe and Stable Families program to provide formula based funds to states to assist them in coordinating services related to child abuse prevention and family preservation.

Other Budget Initiatives

The toll of drug abuse on the individual, family, and community is both significant and cumulative. Abuse may lead to lost productivity and educational opportunity, lost lives, and to costly social and public health problems. HHS will assist states in FY 2006 through the Access to Recovery program to expand access to clinical treatment and recovery support services, and to allow individuals to exercise choice among qualified community provider organizations, including those that are faith-based. This program recognizes that there are many pathways of recovery from addiction. Fourteen states and one tribal organization were awarded Access to Recovery funding in FY 2004, the first year of funding for the initiative. This budget increases support for the Access to Recovery initiative by 50 percent, for a total of \$150 million.

Our request also includes approximately \$18 billion for domestic AIDS research, care, prevention and treatment. We are committed to the reauthorization of the Ryan White CARE Act treatment programs and request a total of \$2.1 billion for these activities, including \$798 million for lifesaving medications through the AIDS Drug Assistance Program.

Finally, we constructed the FY 2006 budget with the knowledge that health information technology will improve the practice of medicine. For example, the rapid implementation of secure and interoperable electronic health records will significantly improve the safety, quality, and cost-effectiveness of health care. To implement this vision, we are requesting an investment of \$125 million. \$75 million will go to the Office of the National Coordinator for Health Information Technology, to provide strategic direction for development of a national interoperable health care system. \$50 million will go to the Agency for Health Care Research and Quality to accelerate the development, adoption, and diffusion of interoperable information technology in a range of health care settings.

Program Performance

The President and the Department considered a number of factors in constructing the FY 2006 budget, including the need for spending discipline and program effectiveness to help cut the deficit in half over four years. Specifically, the budget decreases funding for lower-priority programs and one-time projects, consolidates or eliminates programs with duplicative missions, reduces administrative costs, and makes government more efficient. For example, the budget requests no funding for a number of smaller, duplicative community services programs and the Community Services Block Grant, which was unable to demonstrate results in Program Assessment Rating Tool evaluation. The Administration proposes to focus economic and community development activities through a more targeted and unified program to be administered by the Department of Commerce. It is due to this focused effort to direct resources to programs that produce results that I am certain our targeted increases in spending will enable the Department to continue to provide for the health, safety, and well-being of our People.

Over the past four years, this Department has worked to make America and the world healthier. I am proud to build on the HHS record of achievements. For the upcoming fiscal year, the President and I share an aggressive agenda for HHS that advances a healthier, stronger America while upholding fiscal responsibility and good stewardship of the People's money. I look forward to working with Congress as we move forward in this direction. I am happy to answer any questions you may have.

Chairman THOMAS. Thank you, Mr. Secretary. The Chair would like to thank the Members in the previous meeting in adhering to the 5-minute rule, and the Chair will indicate that there are going to be a series of votes somewhere between 12:30 and 1:00. It will consist of a 15-minute vote on a substitute. There is expected to be then a motion to recommit, with 10 minutes of debate and a 15-minute vote, and then a series of 5-minute votes. The Secretary has a time schedule in which he has to go to the Senate. The Chair will, therefore, not use his customary time, and the Chair would urge those Members who are not strongly motivated in asking questions to consider the possibility of allowing other colleagues. The Chair will indicate that during the roll call vote those Mem-

bers who anticipate asking questions who are near the next Member to be called should go over and vote at the beginning of that 15 minutes and come back. Because the Chair intends to continue the hearing during the 15-minute substitute vote, the 10-minute motion to debate on the motion to recommit, and most of the 15-minute vote on the motion to recommit. At the end of that period of time, we will no longer be able to proceed, given the time constraints of the Secretary. So, with that, the Chair would recognize the gentleman from Florida, Mr. Shaw, for the initial round of questioning.

Mr. SHAW. Thank you. I thank you, Mr. Chairman; and I appreciate your recognizing me at this particular point. Mr. Secretary, you and I go back, back to the mid-nineties when this Committee formed a partnership with some of the better Governors, some of the more progressive, forward-thinking Governors in this country, and together we did welfare reform. I am very pleased to see you back and filling Tommy Thompson's shoes, to continue his fine work, as I was privileged to work with him also, in welfare reform along with Johnny Engler, Tom Carper, and my own Governor Chiles of Florida. You certainly were one of the leaders in that area. I have a particular interest that is of great concern to me. Twenty-5 percent of the deaths in this country are caused by cancer. One in three women will suffer from cancer during their lifetime, and one in two men will suffer from cancer. With this in mind, and knowing and having talked to the people out at NIH, NCI, and Andy Von Eschenbach and others, it is my firm belief that we can conquer cancer by the year of 2015. In fact, we have formed—Collin Peterson and I, both being cancer survivors, have formed a group of Members of Congress dedicated to that purpose.

There is no more frightening words that anybody can hear that I can tell you than when they say, "you have cancer." Mine was lung cancer. I am 2 years out. Very fortunately, I am cancer free at this point. That doesn't in any way change the fact that we need to go forward and find a cure for cancer. It is within our grasp. I am going to be asking the Budget Committee to include extra money within the congressional budget for that specific purpose and to continue that process until we do find a cure for cancer. I would—I do not find the funds that I am speaking of in the President's budget, and I understand that your job is, of course, to follow the President's budget. I want to let you know that some of us will be working very diligently and very hard in order to find those funds so, that we can go forward with the appropriation process and that we can be the lead in the world in this endeavor. I do also, have a question regarding the Medicare prescription drug benefit which goes into effect January 1 of next year. The rollout of the prescription drug discount card didn't go as smoothly as some of us had hoped it would. It was confusing, and I think some of our seniors had problems in navigating the Internet site or did not get their questions fully answered on the 800-Medicare phone line. How will we ensure that the drug benefit rollout will go more smoothly? If you would explain how an average senior can sign up for that benefit. Mr. Secretary.

Secretary LEAVITT. Thank you. Mr. Shaw, may I reciprocate the pleasure I have in being able to work with you again. Those were

remarkable days back in, say, 1995, 1996; and I believe we produced a great milestone in the history of the delivery of human services, one that has benefited many and I hope will continue.

Mr. SHAW. The foundation of welfare reform was belief in the human spirit, and we were right.

Secretary LEAVITT. Indeed we were. May I also, acknowledge your successful recovery from cancer and, understandably, the new insight that you have into the difficulty, the trauma and the disruption that that disease brings into the lives of so, many. Your willingness to champion it is something that I not only espouse but want to be supportive of as well. As you indicated, this is a commitment that we have made as a country. NIH estimates that it will spend \$5.76 billion during the current fiscal year for cancer research. That is an increase from \$5.6 billion from the previous year. For the National Cancer Institute alone, that would be \$4.8 billion. We want to make a considerable coordinated commitment, not just in resources but assuring that the 60 cancer centers around this country are coordinating their activities so, that we have a focused objective to cure cancer as a country; and I believe, in fact, as you do, that we can do so.

With respect to the Medicare rollout, it is clear to me that this is the main event in 2005 for the Department of Health and Human Services. This is another milestone opportunity on the road of human service delivery, and we have an opportunity to deliver into the hands of literally millions the capacity to have prescription drugs. We are committed to doing it well. We have all of the resources of the Department focused on it. I have recently begun to meet with leadership of Congress to ask that they engage with us in a partnership. I would hope that, as the Members of this Committee and the Members of Congress generally go out to their districts at every recess, that we are able to put into your hands information that in fact will help you as Members of this Committee help us and that together we can provide the information to each senior. Now, in terms of specifics, may I suggest—

Chairman THOMAS. Mr. Secretary, might I indicate to you that each Member has 5 minutes in which the question and the answer is to be contained. The question that the gentleman from Florida asked is one that is important to the House. When a question is asked that can't be adequately answered in the timeframe, we would urge that a written response be made to the Committee; and I will make it available to all Members. Because, frankly, the details of the administration's plan to roll out the prescription drug program is one that concerns all Members, and I would prefer not to shrink it to the timeframe which has already expired but rather to get it on paper so, that we can examine it and then have an additional correspondence.

Mr. SHAW. Thank you, Mr. Secretary.

Chairman THOMAS. Thank you. The Chair recognizes the gentleman from California, Mr. Stark.

Mr. STARK. Mr. Secretary, you suggest that you are going to cut or you are going to spend \$50-odd billion in new tax preferences to help individuals purchase insurance, which is where I imagine you—part of where you will get this 8 to 10 million people who gain health insurance. We have been unable, however, to get from

your staff an estimate State by State of the \$60 billion you intend to cut out of Medicaid, is going to knock a lot of poor people out of health insurance. My guess is that if you are going to spend 50 to give states more well-to-do people Health Savings Accounts, if you cut 60 from poor people, you may be cutting 8 to 10 million people out or putting that burden on the Governors. So, I would ask if you could provide to us after these hearings, or have your staff provide to us, your own estimates, which you must have had to get to the \$60 billion, of how many people will lose their Medicaid coverage in each State. I think it will be of interest to all of us to see what your Department estimates. Now, understanding that States will have some flexibility, but, as I say, I am sure that your staff has been smart enough to anticipate that some States may be concerned about that, and I wonder if you would be good enough to share that information with the Members, and we could then make plans to how we answer to our own constituencies.

[The written response from Secretary Leavitt follows:]

Along with the President's proposals to spend over \$125.7 billion over ten years to expand insurance coverage to millions of Americans through tax credits, purchasing pools, and Health Savings Accounts, we must restore fiscal responsibility to the Medicaid program while providing greater flexibility for states.

We modeled anticipated changes to state programs based on the new flexibility in Medicaid to arrive at the estimates in the President's Budget. These changes will enable states to increase coverage for children and other populations for the same Federal dollars. In fact, the budget proposes \$60 billion in savings over ten years for Medicaid and SCHIP. The net savings for these two programs, however, is \$44.5 billion because the budget also includes \$16.5 billion in proposed new spending.

The President plans to expand coverage for the key populations, primarily children, served in Medicaid and SCHIP by spending \$16.5 billion over ten years. The Budget includes several proposals to provide coverage, including the Cover the Kids campaign to enroll more children in Medicaid and SCHIP. In addition, the extension of the Qualified Individual (QI) and transitional medical assistance programs will ensure coverage is available to continue full payment (subject to a spending limit) of Medicare Part B premiums for qualified individuals, and provide coverage for families who lose eligibility for Medicaid due to earnings from employment. Also, community based care options for individuals with disabilities would be expanded through the President's New Freedom Initiative, including authorizing \$1.75 billion over five years for the Money Follows the Person demonstration.

The budget also includes proposals that will assure an appropriate partnership between the Federal and state governments as well as improve the longer term viability of the program. Over ten years, inappropriate federal spending on Medicaid intergovernmental transfers—which deprive providers the funds to which they are entitled, Medicaid drug pricing, loopholes on asset transfers for long-term care eligibility, and spending resulting from other current loopholes in Medicaid law will decrease by \$60 billion.

Medicaid was created in an era when the tools we have at our disposal today were not available. Today, there are ways to better serve the Medicaid population that make better use of the taxpayers' dollars. For example, a tremendous amount of state evidence exists in the area of long-term care that shows serving these individuals in the community leads to more beneficiaries served at a lower cost and a higher level of satisfaction.

The President's Budget provides goals to modernize Medicaid and bring the program into an era that is characterized by creative, innovative and adaptive solutions. Both the President and I want to work with Congress and the states to respond to the challenges in Medicaid and to remove the vulnerabilities that threaten Medicaid's long-term viability.

Mr. STARK. Second, when you were sworn in, the President announced that—he basically issued a veto threat if there were any changes in the Medicare legislation dealing with the prescription

drug plan. Many of us would like to give you the authority or the option to negotiate; and I would, of course, renew my bet with you and give you a chance to double or nothing on that thousand bucks to charity that you just lost—unless you want to accept that bet. You haven't asked your staff yet. That is, a thousand dollar charity contribution in Utah might help. It sure would help in my district, if I am right.

I also, am willing to bet you that, like Secretary Thompson, you would find some areas in which you could save money for my constituents and your program if you were given that authority. If you couldn't save it, I don't know what we have lost by giving you that authority. In other words, if we give you the option to see if you could save money, I am not sure what harm you could possibly do; and you might save us some money. Now, my question is, do you suspect that the President therefore would have to veto any bill that we introduced giving you the discretionary authority to bargain to save some money for the taxpayers? Is it your understanding that that would pull a Presidential veto?

Secretary LEAVITT. Congressman Stark, the President made very clear his commitment to the Medicare drug benefit and I think made equally clear any effort to take that away from seniors would meet his veto. Now I would also, like to make clear that the President believes, as do I, that we should achieve the most competitive, least expensive opportunity for seniors to receive those drugs. He believes, as do I, that that is achieved with a robust market with a choice of alternatives, not just improved prices but improved service, with a capacity for not only drugs, and multiple drugs, but multiple providers and that history has demonstrated, and I believe this will as well, will provide the best possible opportunity for seniors to have both access and low prices.

Mr. STARK. That is a very nice statement. I am sure, Mr. Secretary, you are aware that the Veterans' Administration buys pharmaceuticals at about 50 percent of what the seniors are going to be paying for it and you will be paying under this Medicare drug benefit and that we can all go to Canada, if you would let us, and buy our drugs there at a much lower price. I think that it is not being very creative in not taking advantage of the free market opportunities, and I hope you would reconsider. Thank you.

Chairman THOMAS. The Chair thanks the gentleman from California and asks unanimous consent to place in the record a letter from the Office of the Actuary of the Centers for Medicare and Medicaid Services—Richard Foster is the name that we are familiar with—in front of this Committee and the Committee's strong desire for him to speak from a professional position. The letter that will be placed in the record concludes briefly, quote: We believe that direct price negotiation by the Secretary would be unlikely to achieve prescription drug discounts of a greater magnitude than those negotiated by Medicare prescription drug plans responding to competitive forces. We look forward to a continued dialog with the Chief Actuary at CMS and his independent professional analysis of the law as we move forward.

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES**Centers for Medicare & Medicaid Services****DATE: February 11, 2005****FROM: Richard S. Foster, Chief Actuary****TO: Mark B. McClellan, M.D., Ph.D., Administrator****SUBJECT: Effectiveness of Drug Price Negotiations by the Federal Government versus Medicare Prescription Drug Plans**

Under the Medicare Modernization Act (P.L. 108-173), the new Medicare prescription drug benefit will be provided through private health insurance organizations. In general, health plans that can negotiate favorable retail drug price discounts and drug manufacturer rebates, and take other steps to manage utilization and costs effectively, will be able to offer lower premiums to beneficiaries. Prescription drug plans that are effective in these efforts can gain a competitive advantage over other plans.

We have estimated that Medicare prescription drug plans can initially achieve an average cost reduction of 15 percent (compared to retail-level, unmanaged prescription drug costs), with this reduction increasing to 25 percent over a 5-year period.¹ The ultimate savings level of 25 percent has frequently been achieved in practice by pharmacy benefit managers on behalf of large drug insurance plans. These savings assumptions were reviewed in 2004 by an independent panel of expert health actuaries and economists. The panel found the assumptions to be reasonable and did not recommend any changes to them.

Under section 1860D-11 (i) of the Social Security Act, as added by the Medicare Modernization Act, the Secretary of Health and Human Services is prohibited from participating in the drug price negotiations conducted by Medicare prescription drug plans with drug manufacturers and pharmacies. Similarly, the Secretary cannot establish a price structure for reimbursing covered Part D drugs. The question has arisen as to whether allowing such a role for the Secretary could produce greater cost reductions than the negotiations of individual Medicare prescription drug plans.

My staff and I have not prepared a formal estimate of the impact of eliminating section 1860D-11 (i). We have informally considered the issue and have reached the following tentative conclusions:

- As noted above, Medicare prescription drug plans will have a strong incentive to negotiate effective price reductions. Pharmacy benefit managers have had substantial experience with such efforts and have demonstrated their effectiveness for many years.
- The Secretary's ability to achieve price reductions would depend on the Federal government's willingness to use its large-purchaser power in a forceful way. At one extreme, the Secretary could virtually dictate price levels to manufacturers and retail pharmacies. In theory, such a practice could result in very large discounts, well in excess of our expected levels under the MMA. In practice, however, it is not clear that manufacturers and pharmacies would be willing to sell prescription drugs at very low prices mandated in this fashion. Moreover, we do not believe that the current Administration or future ones would be willing and able to impose price concessions that significantly exceed those that can be achieved in a competitive market.
- Establishment of drug price levels for Medicare by the Federal government would eliminate the largest factor that prescription drug plans could otherwise use to compete against each other. This change would have implications for the degree of competition in the Medicare prescription drug plan market, by reducing the premium differentials among plans. Lower premium differentials would reduce beneficiaries' incentives to select a lower-cost drug plan.
- The past experience of Congress and the Medicare program in regulating drug prices has not been reassuring. A well-known example is the part B covered drugs. Prior to the MMA, these drugs were reimbursed at rates that, in many instances, were substantially greater than prevailing price levels.

In considering these issues, we believe that direct price negotiation by the Secretary would be unlikely to achieve prescription drug discounts of greater magnitude than those negotiated by Medicare prescription drug plans responding to

¹ These estimated cost reductions reflect the combined effect of retail price discounts, manufacturer rebates, and utilization-management programs.

competitive forces. Please let us know if you have any questions about this information.

Richard S. Foster, F.S.A. Chief Actuary

Chairman THOMAS. The Chair would—

Mr. STARK. Mr. Chairman, unanimous consent request to ask at that point a Congressional Budget Office letter to Senator Wyden which says there is potential for some savings if the Secretary were to have the authority to negotiate prices and did not—from therapeutic—with drugs that didn't face competition from therapeutic alternatives and so, forth. I would ask that this letter also, be added with that.

Chairman THOMAS. Without objection, the Chair would also, like to place in the record an additional letter from the Congressional Budget Office analyzing not to a particular Member but rather to the leader of the Senate his determination on exactly that same subject matter.

[The information follows:]

CONGRESSIONAL BUDGET OFFICE

Douglas Holtz-Eakin, Director

February 9, 2005

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

Dear Mr. Chairman:

At your request, this letter discusses the Congressional Budget Office's (CBO's) current projection of spending for the Medicare Part D benefit. That estimate, which was published in the January 2005 *Budget and Economic Outlook*, is nearly identical to the cost estimate for Part D that we prepared in 2003 (see attached table).

In November 2003, CBO estimated that the Medicare Modernization Act (Public Law 108–173) would result in additional direct spending totaling about \$395 billion over the 2004–2013 period. That amount was the net of a number of different types of expenditures and receipts that would result from the legislation. It included an estimated \$552 billion in mandatory spending for Medicare Part D—consisting of \$771 billion in payments for benefits and mandatory administrative costs, offset by \$219 billion in premiums paid by beneficiaries and payments by states. (Those payments by states represent part of their share of the savings from shifting some Medicaid spending for prescription drugs to Medicare.) Those costs were further offset by net savings of almost \$13 billion from changes to Parts A and B of Medicare and estimated savings of \$145 billion in Medicaid and other federal programs because the Part D benefit would reduce spending in those federal programs (largely by shifting some spending for prescription drugs from those programs to Medicare).

CBO recently updated its baseline projections for all Federal programs. As part of that exercise, we modified our estimate of the Part D benefits slightly, mostly to reflect the slightly higher inflation rate in CBO's most recent economic assumptions. That change added about \$6 billion to the projected cost of the Part D program over the 2004–2013 period, raising it from \$552 billion to \$558 billion. The estimated savings to Medicaid and other Federal programs are incorporated in our baseline projections for those programs and are not separately identifiable.

The 10-year projection period that CBO uses for its baseline has changed since the MMA was enacted; it now extends through 2015, thus encompassing two more years of prescription drug benefits. Adding more years to the period covered by the estimate for any program will, of course, add to the total cost being discussed, even when the estimate has not changed at all. By CBO's estimate, net mandatory spending for Medicare Part D will total about \$240 billion during those two additional years.

CBO is currently preparing another update of its baseline projections. As part of the update process, we are reviewing the recently published final rules for the Part

D and Medicare Advantage programs and refining our projection methodologies. The new projections, which will be released in March, will reflect those updated analyses and new information in the final rules.

Sincerely,

Douglas Holtz-Eakin Director

Chairman THOMAS. Any additional dueling letters? With that, the Chair would recognize the Chairwoman of the Health Subcommittee, the gentlewoman from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. Thank you very much. Welcome, Secretary Leavitt. It is really a pleasure to have you here. I appreciate your comprehensive testimony, and we look forward to working with you in much greater detail on the plethora of health initiatives that the President has included in his budget, which will, without question, if implemented in an integrated fashion, begin to forcefully address the problem of the uninsured. I also, appreciate your acknowledging the problem with foster care children. With the Pew Foundation report out there, honestly, it would be irresponsible for this body not to move ahead on a foster care reform initiative that would improve our support for children, many of whom bounce around their whole childhoods from home to home and are thereby literally disabled in moving into adult life. So, I appreciate that. I want to put two questions on the record. I hope you will have time to comment, but they are very important to me.

Let me, though, mention as we move into those questions that your dedication to health information technology is remarkable; and because of the leadership of this President and the Department of Health and Human Services, we are going to have electronic prescribing in place by the time we bring the gift of prescription drugs to our seniors, which will reduce adverse interactions and many, many errors, saving lots of many, saving many, many health problems, including deaths, amongst our seniors. So, let me just put two questions—sorry, one other thing I must mention. When you move dual eligibles, we have to find a special way to deal with the dual eligibles with mental health problems. We can't put them into a plan that requires them to go through a series of medications that they have either already tried or that would not interact well with the complex of drugs they are already taking. That is so, important to me, the unique problem of the mentally disabled, that I think we need to make some special attention there.

My two questions have to do with costs and physician payment. I don't understand why your estimates, your re-estimates of this bill didn't show savings. Your estimates reduced the number that we are going to take of Part D. That should have saved money. It shows more retirees are going to be able to stay with their employers. That should save money. Then it shows that the movement into the advantage plans will be slower. That should save money. In addition, your own disease management pilots you put out there—now, it is only 300,000 out of the 40 million seniors, but only 20 percent of those seniors have five or more chronic diseases. These pilots focus exactly on that kind of senior, and, by agreement, they must save 5 percent. So, those pilots can be rolled out at simply your authority as they prove their success. So, surely

over a 5- to 10-year budget window they are going to have a significant impact on Medicare's cost. Because, for the first time, we are going to focus preventive care on the people who are using the majority of Medicare dollars. Yet that isn't reflected.

So, between your leadership on technology issues, which isn't reflected, and your leadership on disease management, which isn't reflected, and some of the technical changes in the estimate, I do hope that you will take another look. Because I believe we have put in place a program structurally that will reduce Medicare costs as well as improve Medicare quality. On the same line, your budget doesn't provide any indication of your concern about the law that governs physician payment. Indeed, if we let that law go into effect, physician payments will be cut 5 percent for 7 years, for a total of almost a third and overall a swing of 50 percent. I mean, to imagine that that will not have any impact on seniors' access to physicians is to be paying very little attention. I know that nobody in the administration is paying little attention. We need your help in addressing that.

Even CMS has suggested that drugs are an inappropriate component in the SGR formula. Just taking drugs out of that formula would be a huge step forward, and we had excellent testimony laying out the legal rationale for doing that. So, those two issues are pressing immediately on us, but I also, look forward to sitting down with you and, hopefully, with the whole subCommittee and looking at all of the different pieces you have put in place to help us move forward on the issue of the uninsured.

[The written response from Secretary Leavitt follows:]

Estimates of the impact of our disease management programs and the new preventive services need to be based on solid studies of the kind of patients that make up the Medicare population. To this point important studies of disease management programs include individuals covered in the private sector, not in Medicare. However, these studies showed enough positive results for Medicare to begin pilot programs in disease management. We expect that the Medicare pilot and demonstration programs will need at least a year to begin yielding any sort of useful data. It should also be borne in mind that several of our disease management pilots/demos are specifically structured to yield a particular level of savings. Whether expanding these programs nationwide could be done in such a way to encourage a similar level of savings is yet to be seen. Until these studies are complete, however, we do not have the data needed to begin making estimates as to how such modifications to the program might affect overall spending.

The new preventive services provided for under the MMA should improve the quality of care beneficiaries receive. We expect that early detection of disease conditions could result in higher short-term costs as the new services are utilized and paid for, but may also result in better management and possibly lower costs in the long run. However, as with the disease management programs, we need to have experience with how these services affect the Medicare population before we can come to definitive conclusions.

With regard to physician payments, CMS is very aware of the problems posed by the current statutory requirements. Some have suggested that CMS could act to alleviate some of this strain by retrospectively removing drugs covered under Part B from the definition of physicians' services. However, as we have indicated in the past, retrospective removal of drugs from the SGR is statutorily difficult. For example, the statute requires the estimated SGR be refined twice based on actual data. We do not see a legal basis to re-estimate the SGR and allowed expenditures for a year after they have been estimated and revised twice. Further, our current estimate is that removing drugs retroactively from the SGR would not result in a positive update for several years. Consequently, CMS believes that statutory change is needed to improve the physician payments. Moreover, such changes should do more than simply add substantial taxpayer and beneficiary payments to the current payment system.

It is also important to note that our estimates of the impact of prospective removal of drugs from the SGR formula would not provide relief to the negative updates projected for 2006 and the succeeding several years. OACT estimates removing drugs prospectively would cost an additional \$36 billion over 10 years. These changes would also have significant impacts on beneficiary premiums. Consequently, while we have carefully reviewed our authority to make this administrative change, we also have been working with the Congress and health professional organizations on payment reforms that would improve the effectiveness of the payment methodology for physicians without increasing overall Medicare costs.

CMS agrees with you that we need to improve the quality of care delivered to Medicare beneficiaries. As an important first step relating to the quality of services delivered by physicians, in 2006 CMS is implementing a voluntary reporting system to gather information on quality of physician services using a set of key consensus measures. We expect to build on this system in the future.

Mrs. JOHNSON. So, I thank you for your presence. I am sorry I used up all my time, but you really have raised so, many health issues in your budget and so, constructively. I congratulate you on that, and I look forward to moving ahead with you on these specific issues.

Chairman THOMAS. The Chairman looks forward to the gentlemen's written response to the Chairwoman's question. The Chair recognizes the gentleman from Louisiana, Mr. McCrery will inquire.

Mr. MCCRERY. Thank you Mr. Chairman, I will be brief, but I want the Secretary to address the issue of child care funding as it relates to welfare reform. Child care expenditures, Mr. Secretary, have quadrupled since welfare reform was enacted, rising from \$3 billion in 1995 to \$12 billion in 2003. House Resolution 240 adds another \$4 billion in Federal child care money over the next 5 years. It also, increases a share of TANF funds that can be used for child care and allows \$2 billion in so-called carryover TANF funds to be immediately spent on child care. Plus, as you know, we now provide about \$75 billion per year in various tax credits, earned income credit, child care credit, tax child credits to families with children, part of which they could spend on child care directly if they chose. What is the administration proposing on child care funding in the welfare system?

Secretary LEAVITT. Congressman, as reflected in my earlier discussion with Mr. Shaw, we have seen in this country a dramatic improvement in our welfare system, and with it have come dramatic reductions in our caseloads. As a Governor, I want to acknowledge the fact that child care and its availability have been an enormous help and, in fact, could not have been done without the capacity to provide adequately for children whose parents are either working or making other kinds of preparations. With the reduction in caseload, we believe that the budget, as we have proposed it, provides substantial and sufficient funds for that to continue. \$4.8 billion of total funding. Plus, we would like to see added flexibility provided for the States in using existing funds. We believe, with reduced caseloads, with this additional funding, that it is sufficient and that we can continue this remarkable performance that the American people have seen in the transformation of welfare.

Mr. MCCRERY. So, in your view, the funding level for child care in your budget is adequate to take care of the needs of child care in the Nation's welfare system?

Secretary LEAVITT. In our view, it is adequate. I would add to that, that if we were to take all of the children of every low-income qualifying person in the country, we will have seen a 27 percent increase in the amount available since 2001.

Mr. MCCRERY. Exactly. Thank you, Mr. Secretary. I thank the gentleman.

Chairman THOMAS. I thank the gentleman. The Chair would inquire if the gentleman from Michigan wishes to.

Mr. LEVIN. Yes, I want to take up—and I think Mr. McDermott and others will follow up on child care—and welcome, Mr. Secretary.

Secretary LEAVITT. Thank you.

Mr. LEVIN. You know you talked about the additional people who would gain health insurance over the next 8 to 10 years. Your estimate, 8 to 10 million, as he pointed out doesn't point out those who would lose health coverage because of Medicaid cuts. I just want to say to you, or ask you, do you think when there are 45 million uninsured in this country, it is an adequate goal that 8 to 10 million would be added over the next 10 years, even if you don't subtract those who lose it? Is that an adequate goal?

Secretary LEAVITT. Congressman, no.

Mr. LEVIN. Okay.

Secretary LEAVITT. Our goal is 12 to 14 million.

Mr. LEVIN. Of the 45 million?

Secretary LEAVITT. I recognize that there are too many people in this country without health insurance. The numbers I hear are between 35 and 45, and there is a great debate as to what it should be. It is too many, we know that. It would be a constructive and frankly historic step forward for us to be able to improve the lives of 12 to 14 million people by putting health insurance within their reach.

Mr. LEVIN. It is about 1 million a year. That is 1 quarter of those who are uninsured, not taking into account those who lose it. All right. Well, let me go on to child care. I don't think that is an adequate target for the people of the United States. I don't think it is historic. I think it is shameful. Let me ask you about childcare. Has child care funding been essentially kept at the same level since 2002?

Secretary LEAVITT. Since 2001, if you were to divide the amount of child care dollars by the number of children who would be in low-income qualifying homes, it will have gone up by 27 percent.

Mr. LEVIN. Hasn't the funding been flat since 2002?

Secretary LEAVITT. If we look at the per capita amount of money available per child for all qualifying families, who are in low-income categories, it will have gone up by 27 percent per capita.

Mr. LEVIN. The funding, the funding has been flat, no?

Secretary LEAVITT. I can speak to the 2006 budget, but I am not able to reflect on the previous ones.

Mr. LEVIN. I ask because I remember being on the welfare Committee on child reform, and we struggled over child care—according to our calculation with this funding, the number of slots of diminish over the next year's by 300,000. These are the administration's calculations. You mentioned about the transfer from TANF. Right now TANF moneys can be used for child care, no?

Secretary LEAVITT. I am sorry, I missed your question.

Mr. LEVIN. TANF funds can now be used for child care, right, there doesn't have to be a transfer to any other.

Secretary LEAVITT. We looked for more flexibility.

Mr. LEVIN. Okay.

Secretary LEAVITT. One of the things to reconcile—your understanding, with what I have suggested, the caseloads have been cut in half during that same period of time. So, if you look at the per capita amount available for those that are eligible to be served, the amount has gone up 27 percent, and we are seeking \$4.8 billion in increase this year, and we are also, looking to see more flexibility, so, that States have the capacity to serve those who have needs.

Mr. LEVIN. All right. I will ask my colleagues to continue. I want to say a word or ask you about the proposal that has been delayed. You said for a number of years. I want to read you the Utah response to the administration's proposal. Yes, if a major re-direction of resources in policy were to occur, Utah would have likely had to have abandoned the universal participation approach based on individualized employment planning. Employment counselors would become worksite developers and monitors instead of negotiating individualized employment plans tailored to meet the customer's needs to be employed. That was the response from, I think, your welfare director, I think while you were Governor. Would you be willing to sit down with us in a bipartisan basis, which has never happened in this Committee or the subCommittee, and talk about further welfare changes and welfare reform too? Would you be willing to sit down on a bipartisan basis with us?

Secretary LEAVITT. Congressman, I would be delighted to do so. It was with bipartisanship that we produced what I think an extraordinary result in the State of Utah.

Mr. LEVIN. Okay. We will take you up on that. Thank you.

Chairman THOMAS. I thank the gentleman. The gentleman from Michigan, Mr. Camp, wish to inquire?

Mr. CAMP. Would. Thank you, Mr. Chairman. Thank you, Mr. Secretary. I just wanted to talk a little bit about the administration's estimates of the Medicare prescription drug benefit and the cost there. A number of news organizations erroneously reported that the spending for Medicare, the drug benefit, would increase significantly from what we had heard before. Is it not the case that those estimates did not take into account the savings on what I would call the acute side of Medicare, that even though seniors would have the benefit of cholesterol-lowering drugs that would help them manage their cholesterol, that that would not necessarily reduce later hospitalizations due to heart attacks? Were those kinds of factors taken into account?

Secretary LEAVITT. The reports did. Those reports that estimated the number to be about 1 trillion, which was absolutely not

true, did not take into account premium receipts, receipts from States or net Federal Medicaid costs.

Mr. CAMP. It is reasonable to assume, is it not, that the prescription drug coverage would help offset other costs in Medicare?

Secretary LEAVITT. Indeed it is. We expect that there would be other cost savings of about \$188 billion over the period of time being discussed.

Mr. CAMP. This Medicare legislation also, took a different approach to Medicare. There were—and I wonder if you could enumerate some of those—some preventive provisions put in, certainly the first time physical and others, that would help identify problems before they became serious or acute, and so, that ultimately would reduce the long-term costs that Medicare would have to incur. Obviously seniors would be healthier and receive those benefits, most importantly. Were there some of those items in that legislation as well?

Secretary LEAVITT. Actually, Mr. Camp, many. Perhaps the most profound is a requirement that if at any point in time, general revenues of the government would go to support or would need to support at some point in the future more than 45 percent of the total cost, it would trigger an action or a requirement on the part of the administration to make a proposal to remedy it. That has not been done before and is, in my judgment, responsible and an important provision of the bill.

Mr. CAMP. Thank you. Thank you, Mr. Secretary.

Chairman THOMAS. The gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you very much, Mr. Chairman. Mr. Secretary, welcome to the Committee.

Secretary LEAVITT. Thank you.

Mr. CARDIN. We look forward to working on you. I want to follow up on one of the comments made by Mr. Stark and also, Mr. Camp and in regard to the cost of Medicare in the prescription drug bill. Again, I guess I am concerned that the actuary is pointing out that we can expect to get a savings of 15 percent on the prescription drugs, maybe as high as 25 percent, which would still mean that Americans, the government, would be paying for the same medicines for American seniors and disabled, almost twice as much as what the Canadians pay for the drugs, and, in some cases, three times more than our European friends pay for the exact same medicines that are manufactured here in the United States.

So, my question to you is, I would hope that you would make a priority that the Federal taxpayer is not going to continue to subsidize the international communities use of medicines that are manufactured in the United States with help from U.S. taxpayers on research, and that we will fight for a competitive price here in America and tell us what you need in order to bring down the costs to the taxpayers and citizens of our Nation, because that is unacceptable to me. I want to also, move on to the welfare issues, and I want to quote a statement that you made back in 1996 that I agree with. That is, States can better administer programs designed to get people back on their feet, because they understand that people have individual needs and circumstances that are only implicated by the mounds of regulation.

Good statement. I agree with it. I want to encourage you to please look at the welfare reform TANF bill that has been before this Congress in the last two Congresses, that increased the number of welfare recipients in federally-defined work activities that increased the number of work hours required of welfare recipients. Let me remind you that you, as Governor, could have set whatever standards you thought were right for the people of your State. Now, if this becomes law, it will micromanage what your Governor will be doing in Utah and around the Nation, reduce the State's discretion to count training toward work requirements, reduce the State's discretion to count work search toward work requirements. It goes on and on and on. If we are sincere in trusting our States, doesn't this run counter to that flexibility that you and I think is important for a State to assume responsibility to get its citizens to work?

Secretary LEAVITT. Congressman, it heartens me to have a continued discussion of federalism on this subject. I do believe, in fact, that we have seen a remarkable thing occur in this country. My own State is a good example. We were able to take the Welfare Reform Act and provide a dramatic reduction in those that were served by welfare and dramatically increase those that are on payrolls. I believe that what is being proposed does provide flexibility for the States and as a Governor, I would be proud to work under it.

Mr. CARDIN. Well, I appreciate that answer. I served on President Reagan's federalism Commission when I was a State legislator, and I do support federalism. I think it is important. I just don't understand why you would support a proposal that takes away the discretion from the States to define what is important for a person to get off of welfare. I mean, ultimately, they have to live up to a certain standard of getting people to work and off of the welfare roles. There are time limits and law that I support. It seems to me we should trust the States to come up with the best plans to do that and give them the discretion that they need. The language that you are using, I hope that the axle back up the language, so, that we can preserve federalism in the appropriate sense of the word. Let me just last mention provider issues. I have filed with Congressman English today a bill that removed the therapy cap on Medicare for providers, which I think makes no sense at all, and only hurts those people who have serious needs for rehabilitation services. I do think we need a game plan to deal with the provider issues in Medicare. We know the position reimbursement structure is outdated. I look forward to working with Mrs. Johnson, the Chairman of the Committee, Mr. Stark, Ranking Member, and I do hope that we can come up with a package to provide sensible changes in some of the provider issues been that have been really around since 1996, I guess, or 1997, since 1997, that we have yet to fully correct.

Mr. LEVIN. I look forward to working with you on those and others.

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

Chairman THOMAS. I thank the gentleman. Does the gentleman from Texas, Mr. Johnson, wish to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman. You are a refreshing addition to the administration. I appreciate your answers in spite of all the harassment you are getting. In the Medicare Modernization Act, we created health savings accounts, probably one of the most important law that is Congress has passed in a long time. A few of my colleagues and I were working on the President's SAO proposals to expand and strengthen them. However, in order for consumer-driven plans to work, there has to be accurate and comprehensible quality data available. Otherwise, you know, you are driving blind in respects. In my district, a private not-for-profit group called The Patient Safety Institute, you may be aware of it, has developed a clinical information network that requires only an Internet connection to access it. The benefits of their system are almost too good to be true.

Rather than costing billions of dollars, their system functions off of a user fee much like the ATM system, and they have enjoyed huge success in every pilot city that they are up and running in. In fact, you may recall that the Western Governors Association supported their efforts along the way. Ideas like this have the potential to offer health consumers a huge advantage, and with minimal use of taxpayer money. I see that the President has made health information technology a priority in his budget. I wonder if you could tell me what efforts are being made to work with the private sector on this issue.

Secretary LEAVITT. Congressman, may I say that my instinct leads me to precisely the same place that you have enumerated, and that is to transform healthcare in this country, we must provide for the benefits of technology to transform medicine. For its delivery. The President has made a proposal for \$125 million this year. More importantly than that, we need to turn to the power of every agency in government, every State government. We need to harness a collaborative effort between private organizations like the ones you have referenced and large payers, and we need to develop a system that will deliver healthcare in ways that will prevent mistakes, lower costs and provide better care, and we are capable of doing it. This is a country that can perform on this, and this is one that we have to perform on. We are now at the point where 15 percent of the gross domestic product is being devoted to healthcare. Many of those whom we compete with around the globe are doing it more efficiently than we are. Ultimately, that will come home to roost. We have to do this better than we are doing it, and the kinds of initiatives you have spoken of in my judgment are primary to that effort.

Mr. JOHNSON. I appreciate it. Free enterprise does work, doesn't it. Thank you, Mr. Chairman. I yield back.

Chairman THOMAS. I thank the gentleman. The gentleman from Ohio, Mr. Portman, wished to inquire, and prior to recognizing the gentleman from Ohio, I have been informed that there is a birthday card in the Democratic cloak room for those who remember or wish to sign the 80th birthday card from the former gentleman from Ohio, Mr. Louis Stokes.

Mr. PORTMAN. Thank you, Mr. Chairman, and Mr. Secretary, welcome aboard. We are delighted to have you in this critical position during what will be a challenging year for all of us, dealing

with Medicare and Medicaid costs. I just left the Budget Committee where we talked about the fact that if we don't do something to restrain the growth in healthcare spending that by the year 2040, Medicare and Medicaid alone will have costs that will exceed the current budget as a percentage of the GDP. So, clearly, we need to think smarter and, Mr. Johnson talked about some ways to do that which you talked about as well in information technology, and adding competition and transparency, and flexibility to the system. One of the issues that has come up in my State, and I know around the country, is the relationship between Medicare and Medicaid on so-called dual eligibles. Those are low income senior citizens, many of whom get long-term care from Medicaid. Although technically Medicaid isn't supposed to provide long-term care it does through home health and skilled nursing facilities, but also, gets the prescription drugs through Medicaid. If you could talk a little bit about how it would be helpful to the Committee, how you think the proposed reforms in this budget to Medicaid, for instance, might impact the long-term care service for dual eligibles, and specifically, how Medicare and Medicaid should interact with regard to dual eligibles. If you like to follow up with a letter, that would be fine. I wondered if you had any thoughts on that for us today.

Secretary LEAVITT. I would like to address, Congressman, the topic generally on long-term care, because I believe it is among the more challenging topics we have to deal with. There has been some discussion in this Committee this morning about Social Security. That is a demanding issue that needs to be dealt with. Long-term care is every bit as critical as Social Security and being able to deal with it over the long term. There is a point in the life of every problem, when it is big enough that you can see it, but small enough that you can still solve it. That is where we are on long-term care. The President has proposed in his budget \$3.7 billion over the next 10 years, to begin a transition for those who are served as elderly or disabled to be able to be served in their home or in their community as opposed to being essentially required to be served in an institution. That is just one of many reforms that I believe we can make in both our Medicaid and our Medicare system to allow us to cope properly with that.

While I am on the subject of dual eligibles, may I make a reference on the Medicare rollout. A subject that has been of some concern, of grave concern to many, is how we will transfer those who are currently served by Medicaid onto Medicare to assure that there is no loss in their coverage or their capacity to reach prescription drugs. Because many of those seniors will be required to make a decision early, we have taken the action to ensure that no one drops through the cracks by ensuring that all of those seniors will have a decision made for them, if not by them. That shortly in the periods that ensue afterward, we will be highly flexible in working with each one of them to ensure that, in fact, it has been made in a way that suits their interest. No seniors, transitioning from Medicaid to Medicare will lose their coverage because of lack of action.

Mr. PORTMAN. That is very helpful. I know, again, there is a concern, certainly, in my State and around the country on that, and that is very helpful, in particular, with regard to our dual eligible seniors. We also, appreciate, though, your willingness to better

communicate, perhaps than we did, even with the prescription drug card to our seniors, what benefit will be available on January 1st of next year, and you and I have talked about this separately. I know the Committee is going to be eager to work with you on that rollout more generally as well. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. Does the gentleman from Washington, Mr. McDermott, wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman. Mr. Secretary, we welcome you. Here you are up and playing a new game. You were a Governor and when the Republicans sent out the new welfare program, the new TANF bill, you said resources will have to be diverted from current services such as pregnancy prevention, training programs, marriage initiatives, fatherhood programs and other child well-being initiatives in order to meet the cost of providing work sites to meet the Bush-proposed work requirements. Now, it sounds like, in fact, I know that you are one of the few States that counted 24 months of going to school as being work requirements. The President's budget, as presented that you are now here defending and going to try to implement, says you can only count 3 months.

Now, I would like to hear you explain to me why you think the present Governor of Utah should have to cut that flexibility to see kids go or young women go through school for 2 years and have that count, instead of cut it back to 3 months. Where is the policy judgment? Where is the proof that this new work requirement makes it better? Because Ron Haskins, who was our former staff guy and worked in the White House, says there is no evidence for that. I wonder why, or how you feel about pushing that on your successor back in Utah?

Secretary LEAVITT. Well, Congressman, we worked very successfully, as you have enumerated, in being able to transform the lives, not just the system, but the lives of those who were served. It ultimately resulted in a complete reordering of the way we approach it. We began to make our system, rather than a welfare system, into a system that helps people get back on their feet. You were part of that, most on this Committee was, and we worked very successfully under it. I have every confidence that the existing Governor of Utah will take the construct that I helped reauthorize and will responsibly balance those to do the same thing.

Mr. MCDERMOTT. The system that you are implementing takes away his flexibility. Is it your intention to sort of ignore what is in the law and use your waiverability to let every Governor do what they want?

Secretary LEAVITT. Congressman, we will keep the law.

Mr. MCDERMOTT. Well, it is following the law. You are just ignoring the requirements of the law and give a waiver to a State to do something else. You are saying that you are sure you will be able to do it, because you will give them that power; correct?

Secretary LEAVITT. In 1995 and 1996, when I appeared many times before Congress as a Governor to discuss this, it was an issue then. What we concluded, and I was in complete agreement, then and now, is that work is an ennobling virtue, that people need a plan to move forward in order to have their lives transformed.

Mr. MCDERMOTT. I don't think anybody disagrees with that Governor, no one disagrees with that. The question is how rigid you make it and what you are willing to count. If education doesn't count anymore, then the question is it just getting people off welfare or is it trying to get them up the economic ladder, get them out into poverty, another kind of poverty, or do you want to give them the way to get out. I just want to call your attention to this chart over here. Because this is the chart that has to do with child care. Now the bottom part—the top part of it is the 8.3 billion in costs, that part right there, that comes from the new work requirements. This is from CBOE. This isn't made up by Democrats. That is their requirement, and this part down here is what is maintenance of effort, right now. Your—this budget creates that much more capacity, and you leave yourself with \$10 billion hole to fill. Now, I know you say we are going to fill it from money that is left in States. So, I went and got the list.

The first 13 States at the end of 2003 had not one single dime of unobligated money, California, Colorado, Connecticut, Illinois, Indiana, Louisiana, Massachusetts, Oregon, South Carolina, Tennessee, Vermont, Washington and Missouri. None of those States had a single unobligated dollar and you are saying well, they will just move these dollars that they have been holding back over into this program. They don't exist. How are those governors going to raise this money? How are they going to provide the ability to fill that hole? I mean, that is a hole in every State legislature today. How are they going to do that?

Secretary LEAVITT. Congressman, I have wrestled with these problems.

Mr. MCDERMOTT. I know you did.

Secretary LEAVITT. I know, in fact, it can be done and I know we were better off as a result. There are a number of areas, welfare being only one of them, where with additional flexibility Medicaid would allow States to be able to deal with these problems in a way that meets high national standards, expectations that we set for ourselves and at the same time be able to do just what is called for, and that is a continued movement of people off welfare and onto work.

Mr. MCDERMOTT. I like what you say, but it doesn't follow the bill. The bill limits flexibility. That is the problem.

Chairman THOMAS. The gentleman from Pennsylvania, Mr. English, wish to inquire?

Mr. ENGLISH. Thank you, Mr. Secretary. Again, welcome. As we have seen from the hearing, from this hearing, that over the years, since we implemented the 1996 law, there are far more advocates of flexibility that when we started. On the point of the 1996 reform, sanctions for failure to work and time limits on benefits have been directly correlated with higher income gains among welfare recipients, which is exactly the opposite of what the critics have predicted. Unfortunately, in FY 2003, States reported that only 31 percent of families with an adult recipient, participated in the required 30 hours of TANF work activities. Given that work rates have fallen among welfare recipients, in 3 of the last 4 years, is the administration proposing any changes to its work requirements or check sanctioning in this year's TANF proposal?

Secretary LEAVITT. Congressman, I am going to tell you, I don't know specifically what has been proposed to prior in to the last couple of months, so, I am not able to respond specifically to what the proposals in the negotiations have been.

Mr. ENGLISH. Then may I specifically ask, is the administration now receptive to the notion of full check sanction, something that studies have demonstrated has the potential to engage welfare recipients and ultimately make more of them aware, in some cases, that they aren't meeting the standards?

Secretary LEAVITT. I am being quickly briefed on just what the State of the discussions have been.

Mr. ENGLISH. I understand.

Secretary LEAVITT. I will say to you and other Members, I have been on the job now 20 days.

Mr. ENGLISH. I fully understand.

Secretary LEAVITT. Thank you. Congressman, let me just say, I am delighted to be working on this subject. This is a subject that is near and dear to me. I will work with you and other Members of the Congress. I believe strongly in the virtue, in the ennobling ability of work to transform people's lives. I recognize that that's the standard we are after. It has the capacity to balance the need between people to improve and continue to be self-reliant. I am not able to conduct a conversation on this point right now, but I would be delighted to do it either in writing or in person.

[The written response from Secretary Leavitt follows:]

The Administration continues to support State flexibility in use of the full check sanction as currently allowed under the TANF program. However, we recognize that there is a substantial body of research demonstrating the advantages of the full check sanction.

The purpose of sanctions is to encourage compliance with work requirements leading to self-sufficiency. A critical benefit of strong work expectations and activities is the ability to acclimate recipients to a working lifestyle—not simply learning how to do a specific job, but to learn through experience what it takes to be employed and remain employed. A weak sanctioning policy could undercut these expectations and do serious damage to a family's prospects to achieve self-sufficiency. When welfare-to-work participants who refuse to comply with requirements continue to receive partial benefits, they and their families also can be placed at considerable risk as their time-limited months of assistance are used.

The frequency and severity of sanctions, including "full-family" or case closure, has increased under welfare reform. In some States, nearly half of all recipients experience a sanction over time. Most people are sanctioned because they fail to show up for appointments. Under current law, if an adult refuses to engage in required work, a State has the option to either reduce pro-rata or terminate the amount of assistance payable to the family, subject to good cause. In the first instance of non-compliance, 36 States impose a partial-grant reduction, 14 States impose a 100% grant reduction, and one State gives a written warning. All States increase the duration or the amount of the sanction for repeated noncompliance. Ultimately, 36 States impose a full-family sanction or 100% grant reduction, and 15 States continue a partial-grant reduction.

Mr. ENGLISH. We will certainly do that. As a follow-up, Mr. Secretary, I have been—and this may also, be something we want to correspond on. I have noticed that the administration's budget proposes \$1.5 billion in cuts to specifically Medicare funding for nursing home care. One of the ideas that I have had is that perhaps a better way to encourage quality is to expand the pay for performance concept to SNFs. Last year I introduced legislation on

this subject and I intend to do it again. This legislation would for the first time link the amount of Medicare reimbursement received by a skilled nursing care provider to a qualified provider of that facility. I think this is the way to go to incentivize skilled nursing facilities to continue making quality improvement a top priority. In my view, this is maybe a better alternative than the scale of cuts that we have been contemplating, and I would welcome an opportunity to work with you on this issue.

[The written response from Secretary Leavitt follows:]

To clarify, the budget did not propose \$1.5 billion in cuts, but rather it anticipated that CMS would implement SNF case-mix refinements, which under statute would result in the elimination of the add-ons. The add-ons were costing Medicare \$1.5 billion per year, for every year that we did not implement the refinements.

In the final SNF PPS update regulation for FY 2006, CMS implemented these refinements, which will result in more accurate payments. The refinements become effective on January 1, 2006, effectively extending the add-on payments for an additional calendar quarter. We made other adjustments to the payment system, resulting in retaining one-half of the amount of the add-on in the payment system. Finally, SNFs also received the full market basket update for FY 2006. The cumulative effect of these adjustments means that in FY 2006, total Medicare payments to SNFs will be about \$20 million greater than payments made in FY 2005, which is an increase over the level payments we had predicted in the proposed rule.

Linking quality performance to payment is where health care is heading in the future. Quality of care is a top priority for this Administration and linking payment to performance is a proven way to improve and promote quality care.

Further, the Medicare Modernization Act of 2003 (MMA) propelled pay-for-performance forward by linking Medicare's annual update for inpatient hospital services to the submission of quality data. Nearly all of the nation's eligible hospitals have begun reporting data on the quality of care they deliver, which is a vital step in improving patient care.

While we do not have a formal position on your proposed legislation, we strongly support the development of pay-for-performance programs for SNFs as well as for other care settings. In fact, we are actively exploring SNF pay-for-performance design options, and have identified several basic criteria that we think will lead to success.

During the September 20, 2005 special Open Door Forum, CMS discussed the recent development of an initiative called Nursing Home Pay for Performance. Under this demonstration, financial incentives would be provided to nursing homes that meet certain standards for providing high quality care. As this demonstration is currently underway, we have been including stakeholders in the development process to ensure that this demonstration is a successful one.

Secretary LEAVITT. Thank you.

Mr. ENGLISH. Thank you, Mr. Chairman.

Chairman THOMAS. Would the gentleman yield briefly?

Mr. ENGLISH. I would be delighted.

Chairman THOMAS. In a partial response to the gentleman from Washington's chart from the Congressional Budget Office, which we are, of course, by law, required to follow up, I think it is interesting, because obviously these are based on methodologies which may or may not be substantiated by looking at previous estimates and what occurred with the previous estimates. In 1996, when the program began, the estimate by the Congressional Budget Office was that by the year 2002 there would be a \$14 billion shortfall. What occurred, of course, in 2002, was a \$6 billion-plus amount in State coffers that had yet to be spent. So, whenever someone tells me about a continuing pattern based upon assumptions that have proven in the past not to be accurate, you anticipate some modifica-

tion and estimate as basically the caseload question whether or not the caseloads would be modified. I thank the gentlemen.

Mr. MCDERMOTT. Mr. Chairman, following the regular order, may I comment on your response?

Chairman THOMAS. I borrowed the time from the gentleman from Pennsylvania because his time had not expired, and he yielded me the portion of his time, which has now expired. The Chair recognizes the gentleman from Missouri, Mr. Hulshof.

Mr. HULSHOF. Thank you, Mr. Chairman. I would say to my friend from Pennsylvania, it appears that we not only have new converts to flexibility, but new converts to welfare reform generally. Mr. Secretary, welcome. I think your appointment and confirmation, excuse me, has demonstrated yet again the President's extraordinary ability to appoint highly qualified individuals to important cabinet positions, and we look forward to working with you during your tenure, recognizing that the short time you have had on the job, I don't want to greet you with a high and tight fast ball, but I do want to express a concern, and it is a concern not just limited to Missouri, but a letter that we sent back in July of 2004, and it relates specifically to an interpretation by the Center for Medicare and Medicaid services that I think could compromise the use of volunteer faculty in graduate medical education programs.

A scenario, Mr. Secretary, in rural parts of my district and really across the country, it is not uncommon for residents to train in a physician's office, in a clinic or in some other nonhospital sites. A recent Office of Inspector General report, in fact, illustrates that in many of these cases, the supervising physician is working on a volunteer basis. What doctors have told me and others is that gives them a sense of pride to really give back to the profession the ability to pass on their knowledge and their expertise to this younger generation of physicians. Last year, as I mentioned in this letter, there were, I think, 116 signatories from both political parties, some on this Committee, some not, that expressed our concern with then CMS's policy, and let me say even arbitrary policy, disallowing hospitals the ability to claim for payment purposes from GME payment purposes, the time that residents spent in these nonhospital settings.

In fact, further concern is that in 2002, CMS began denying and sometimes retroactively through audits, payments for the time that residents spent in these nonhospital settings and where supervisory faculty volunteered their services. Again, those of us who sent the letter back in July of 2004 thought that this was really not Congressional intent. Along that line, when we passed the Modernization, the Medicare Prescription Drug and Modernization Act of 2003, we put in there a temporary moratorium on CMS's ability to have payment denial. So, again, I just set that up for you. What I would ask, because we never got a response to our letter, would be we would resubmit the letter to you, as we did back in July of 2004, please take a look at it. Again, this is just a concern, in light of this, the volunteer basis, and especially in these rural settings, and, again, I welcome you here. You don't need to comment necessarily, because this is kind of a specific point. I would welcome your response to that point as soon as you can make it. Thank you, sir. I yield back, Mr. Chairman.

Secretary LEAVITT. I will do my best to respond in a written way.

[The information follows:]

Thank you for your continued interest regarding Medicare graduate medical education (GME) payments to hospitals for training residents in non-hospital sites. On April 12th of this year we sent you a letter discussing this issue. Specifically, we addressed your concerns regarding the Centers for Medicare & Medicaid Services' (CMS') policy requiring hospitals to pay for the cost of the teaching physicians that are volunteering their time to teach residents in the non-hospital setting.

As we discussed in that letter, volunteerism is certainly encouraged under the Medicare Program and we are doing everything we can under the statute to facilitate the use of such volunteer faculty. As you know, the Social Security Act allows a hospital to include the time a resident spends in non-hospital settings in its indirect medical education (IME) and direct GME full time equivalent (FTE) count, if the resident is spending his/her time in patient care activities, and the hospital incurs "all or substantially all" of the costs of training the resident(s) in the non-hospital site. The response we sent to your letter detailed the specifics of the statute and our regulations that form the basis for our policies regarding reimbursement for graduate medical education rendered in a non-hospital setting.

CMS recognizes the value of training more residents in non-hospital sites and we intend to make sure our rules are clear in order to encourage this activity. Since our response letter was sent to you we have posted on our website a list of frequently asked questions and answers on volunteerism and Medicare graduate medical education payments to clarify our policy for hospitals, non-hospital sites, and physicians. These FAQs can be found at the following web address:

<http://www.cms.hhs.gov/providers/hipps/nonhospQA.pdf>

In response to some additional questions and concerns that we have received on this issue, CMS has also had a number of formal and informal discussions with Members of the public and hospital industry to discuss how we could better clarify and convey our policies. These discussions are ongoing and we hope to emerge from them with a better understanding of volunteer training and the extent of potential reimbursement possible under the law.

Thank you for your continuing interest and concern on this topic. I greatly appreciate all of the efforts you have made to ensure a full and fair payment system for the graduate medical education program. If you have any additional questions, or if I can be of any assistance, please do not hesitate to let me know.

Hon. Kenny Hulshof
House of Representatives
Washington, DC 20515

Dear Mr. Hulshof:

Thank you for your letter regarding Medicare graduate medical education (GME) payments to hospitals for training residents in non-hospital sites. Specifically, you are concerned with the Centers for Medicare & Medicaid Services' (CMS) policy requiring hospitals to pay for the cost of the teaching physicians who are volunteering their time to teach residents in the non-hospital setting. Volunteerism is certainly encouraged under the Medicare Program and we are doing everything we can to facilitate the use of such volunteer faculty.

The Social Security Act allows a hospital to include the time a resident spends in non-hospital settings in its indirect medical education (IME) and direct GME full time equivalent count, if the resident is spending his/her time in patient care activities, and the hospital incurs "all or substantially all" of the costs of training the resident(s) in the non-hospital site. "All or substantially all" is defined in regulations as the residents' salaries and fringe benefits (including travel and lodging expenses where applicable) and the portion of teaching physicians' salaries and fringe benefits attributable to training residents.

In the case of volunteer physicians, many hospitals have written agreements with the teaching physicians that state the physician is volunteering his or her time and, therefore, the hospital is not providing any compensation to the non-hospital site for the teaching physicians' time. However, this may conflict with the requirement that in order to be reimbursed for GME the hospital must incur "all or substantially all" of the costs.

In order for the hospital to incur “all or substantially all” of the costs, the actual costs of the time spent by teaching physicians in supervising residents in the non-hospital setting must first be determined. As long as there are teaching costs associated with the non-hospital training, the hospital must identify and reimburse the non-hospital site for those costs in order to count the residents training at that site for purposes of direct GME and IME payments. For example, in instances where the teaching physician receives a predetermined salary, the costs of training residents are included in the salary, and the hospital must reimburse the site for an amount based on the percentage of time the teaching physician spends training the resident(s). Determination of the teaching GME costs would be dependent upon the teaching physician’s salary and the percentage of time he or she devotes to activities related to the residency program at the non-hospital site. Accordingly, the fact that the non-hospital site is incurring a cost (i.e., the salaries) for the physicians’ time which includes teaching time, indicates there are teaching physician costs of training the residents, even if the physician states that he/she is “volunteering” his or her time to supervise the training of residents.

In other cases, there may truly be no supervisory teaching costs associated with the non-hospital training. For example, where the teaching physician is a solo practitioner, since the physician’s compensation is based solely on the bills the physician submits for the patients he/she treats, there is no compensation, and therefore no cost, for the time the physician spends on GME activities. Accordingly, in that case it would be appropriate for the written agreement to state there are no teaching physician costs at that site to be reimbursed by the hospital. Before residents training at a non-hospital site can be counted by a hospital for GME purposes, the hospital must first determine, based on the specific arrangements at that site, whether there are teaching physician costs.

Section 713 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided for a time-limited exception to the requirement to incur “all or substantially all” of the costs of training. Pursuant to this section, during the 1-year period from January 1, 2004, through December 31, 2004, CMS is to allow hospitals to count allopathic or osteopathic family practice (no other specialty) residents training in non-hospital settings for IME and direct GME purposes, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital setting to which the resident is assigned. CMS implemented this provision in a one-time notification issued on March 12, 2004, and solicited and responded to public comments in the fiscal year 2005 Hospital Inpatient Prospective Payment System proposed and final rules.

In accordance with section 713(b) of the MMA, the Office of the Inspector General (OIG) conducted a study of the appropriateness of alternative cost methodologies for costs of residency training in non-hospital settings. The OIG issued a report in December 2004 that detailed the results of the study and made recommendations regarding Medicare payment for residents training in non-hospital settings. I have enclosed a copy of the OIG report and a copy of CMS’ response to the report’s recommendations.

We appreciate the value of training of residents in non-hospital sites and want to facilitate further development of this practice in accord with the statute. Consequently, we intend to make sure our rules and our methods of implementing them are as clear as possible. In particular, we will be posting on our Web site a new set of frequently asked questions on volunteerism and Medicare GME payments.

In addition, we are conducting a review of our audit procedures to determine whether we should update our guidance to our fiscal intermediaries. Given the rate of change in the practice of medicine, we want to make sure our rules and audit procedures are kept current. We also want to make sure we are meeting our primary objective of providing high quality, cost-effective care to Medicare beneficiaries.

I appreciate your interest in this important issue. I will also provide this response to the cosigners of your letter.

Sincerely,

Mark B. McClellan, M.D., Ph.D.

Chairman THOMAS. I thank the gentleman. The gentleman from Georgia, Mr. Lewis.

Mr. LEWIS OF GEORGIA. Thank you very much, Mr. Chairman. Mr. Chairman, I would like to yield a minute to my friend and colleague from Washington, Mr. McDermott.

Mr. MCDERMOTT. Thank you. Thank you very much. Mr. Chairman, your argument was that 1996 the child care estimates made by CBO were far off. Because they didn't take into account the caseload reduction, but what you didn't say was that in 1996 we put in \$4 billion. If you look at that chart now, you see we are putting in 1. If you put in 4 more, well, you would cut this down in half, and that's the real issue. You are only covering 10 percent of it now.

Chairman THOMAS. Would the gentleman yield?

Mr. LEWIS OF GEORGIA. Thank you, Mr. Chairman, Mr. Secretary. Welcome. Mr. Secretary, this budget is about our values. Our priorities, as a nation and as a people. Do you think, or do you really believe that this budget is friendly to the basic needs of the American people. If I might continue, is there anything in this budget that will close the growing and unbelievable disparity gap between the minority population and the majority population, African-American, Hispanic, native American, low-income groups and others. If you can elaborate.

Secretary LEAVITT. Congressman, I do believe it is a budget that deals with the values of this Nation. Let me just use a couple of examples, community health centers. The President made a commitment that we would see 1,200 new and expanded community health centers. This budget not only helps meet that, but adds an additional 40 that will go to the poorest counties in America, and will serve some 6.1 million additional people over the course of the next year. Another example, Medicaid. Much has been said already about the fact that the President has proposed some changes in Medicaid. I would like to explain what those changes are. One of the changes is a clear statement that we are paying too much for prescription drugs in Medicaid, and that if we were to make a change in the way we do so, we could save \$15 billion in the next 10 years. That money in large measure could be used to care for children. In fact, he has proposed an additional \$10 billion to go for the care of children. He has also, proposed that we allow for families to be able to care for the elderly and the disabled in their home if they choose to, as opposed to institutions. I think that speaks to the values of this country, that we believe in caring for our parents and being supportive of them and being able to support those who care for—so, Congressman, yes. I believe that there are many provisions of this, that speak directly to our values.

Mr. LEWIS OF GEORGIA. Let me just ask you, have health centers substituted for coverage and disparities that exist?

Secretary LEAVITT. Congressman, it would be my aspiration that health insurance would be within the reach of every American. Sadly today, somewhere between 35 million and 45 million have not yet achieved that. Among those, however, are a large population of people who have not yet accessed health insurance but do receive healthcare.

Mr. LEWIS OF GEORGIA. Mr. Secretary, I don't want to interrupt you but I travel a great deal. I have been to Provo, I have been to Park City and I have been to other places in Utah, and I

have been all across America, and in the heart of the American south, and the southwest and Appalachia. You may have some health centers in some and they are doing good work. The gap in disparity is unbelievable when you come to the question of hypertension, diabetes, prostate cancer, HIV and AIDS. As a nation and a people, we should be able to do much better.

Secretary LEAVITT. Congressman, that is the American aspiration, and this budget is directed to that. The President sees a nation where, in fact, we do have the capacity to someday, ensure that every American has health insurance within their reach. He sees the capacity for us to do away with cancer and diabetes as diseases and has appropriated billions of dollars toward that end. To better manage those dollars he suggested and proposed changes in the way we go about it to ensure that we can. That is a dream we share.

Mr. LEWIS OF GEORGIA. My time is about to run out, but there is a recent study on medical bankruptcy that found about 50 percent of all bankruptcies were filed because of high medical bills. Are you concerned about that at all?

Secretary LEAVITT. Deeply concerned.

Mr. LEWIS OF GEORGIA. Well, why is the administration pushing these high deductibles?

Secretary LEAVITT. Because we would like to see health insurance within the reach of every American, and we are dealing with a system that is fundamentally not efficient, that is a way for us to make it more efficient and to put it into the hands of more people. Congressman, I have recently changed my own medical insurance to a health savings account. I see it as a great opportunity. While I was Governor, I worked to create health plans that would allow us to provide could have acknowledge, some coverage to more people, as opposed to a limited number having all coverage. Those are the kinds of value judgments I believe we need to make, all reaching to the same goal, and that is for health insurance to be within the reach of every American.

Mr. LEWIS OF GEORGIA. Thank you, Mr. Secretary.

Chairman THOMAS. The gentleman from Florida, Mr. Foley.

Mr. FOLEY. Thank you, Mr. Chairman, and I welcome you, Mr. Leavitt, to our hearing and thank you for your emphasis and the President's on community health-based solutions. I represent some of the poorest counties in America and the richest. So, I have a dichotomy of population, Glades County, Hendry County and I visited personally the community health centers delivering quality care in an atmosphere of compassion for those who have meager incomes, don't feel as if they are charity, they feel they are getting good quality health care. Medicaid—and you will be receiving from Florida's Governor Jeb Bush, I believe, the President's favorite governor, maybe second to you, some interesting revamping of Medicaid in our State from a top to bottom State-run system to a more market-based, citing community health centers as one of the ways to triage. I hope you will be favorable to some of the request of waivers he may make of your department. Second, I think we all agree that there have been some horrific cases in the news regarding child care in Florida, in New Jersey, in the foster care system. I am one who generally likes to see the States handle their own

work product. I feel there's an urgent need for us as a nation to look at the quilt of laws that apply to child welfare and look at ways in which we can either streamline or better protect the children in the custody of foster parents. We track library books better than we do our children, and we have seen too many cases of abuse.

I would like to urge you, as Secretary, to undertake a thorough look see at how the States operate and how we may be able to work as partners, if you will, sharing information across State lines and the fitness of people. People move. They leave States. We can't go after their backgrounds and find out if they have prior criminal convictions or child abuse convictions. So, a lot of things I think could be helped by your agencies efforts in that direction. Finally, again, on the health centers, just to underscore the importance the President placed at the State of the Union and, of course, followed up with real dollars. I also, wanted to take a moment in that same line of thinking, because the pharmaceutical industry does come under attack by almost everyone, both Republican and Democrat. They have provided some valuable resources to some of the poorest in my community through the sharing programs, taking care of those who have no eastbound come to provide drugs, provide opportunity for them. So, I think while we can lambaste them for a number of things, I do think we also, have to acknowledge some of the significant role they play in delivery of drugs to those who cannot afford any type of coverage.

Secretary LEAVITT. Congressman, just two quick responses. The first is that there is now a spirit of innovation that I believe is occurring in States with respect to providing access to health care to more people through Medicaid. There is great concern on the part of Governors, for example, that they are being forced to release from coverage optional groups that they badly want to cover. Governor Bush, I look forward to hearing more about his waiver request. With respect to child welfare, may I tell you that this was among the most difficult problem that I dealt with as Governor, and I believe any Governor. I have knocked on the doors of families and said with a caseworker to a mother, I need to speak with you privately or your children privately. I know the anguish that they face every day. This is among the most difficult things that a government deals with. We need high national standards that States can meet. We also, need to give States the capacity to meet them with the levels of flexibility and the means by which they can find the best way to do so.

Mr. FOLEY. I would love to work with your legislative staff to develop some proposals.

Secretary LEAVITT. Thank you.

Mr. FOLEY. I yield to the Chairman if he wishes inquire.

Chairman THOMAS. I thank the gentleman. Would the gentleman from Connecticut wish to inquire?

Mr. LARSON. Thank you Mr. Chairman and Mr. Secretary, and thank you for your distinguished service as Governor.

Secretary LEAVITT. Thank you.

Mr. LARSON. From everything I have heard about you, your reputation precedes you and from this dialog this morning is suggestive of your commitment. I think the President has chosen well.

Secretary LEAVITT. Thank you.

Mr. LARSON. My concern is a direct one for the constituents in my district, especially as it relates to prescription drugs. Quite frankly, they feel like they are refugees from their own healthcare system. Having to travel to Canada, in order to afford prescription drugs, while their neighbor next door goes to the local VA and gets a deep discount, or the person next door who works for Wal-Mart who has their corporation negotiate directly on their behalf. I am all for market forces. As Mr. Cardin points out, when we end up having the more than 40 million elderly in our country, in essence, subsidize the rest of the world, why they continue to pay exorbitant prices for prescription drugs, is it the moral responsibility of government to step in at this point and negotiate directly? My question is, if we were able to give you the authority to do that, would you encourage the President not to veto that in a proposal that would change the current law?

Secretary LEAVITT. Congressman, we have an opportunity, I believe, in the next year, that is historic, and that is to put into the hands of our seniors and those who will be otherwise eligible, a powerful new tool and benefit, not only to receive prescription drug, but to receive them at the lowest possible price. That tool is a robust market with choices, not just of plans but of medicines. There is no power on Earth greater than a market to find that place, and I believe that we will. In fact, seniors—

Mr. LARSON. Should the market fail to produce the robust kind of discount, would you be willing to negotiate directly on behalf of the more than 40 million people for the discounts, the same kinds of discounts that are enjoyed by the VA or by people in the corporate sector who negotiate directly for those same kinds of discounts, but not nearly with the kind of leverage that you could have with more than 40 million people.

Secretary LEAVITT. Congressman, as recently as day before yesterday, we received the good news that one marriage company will be offering a national plan. Others, I believe, will follow. We will have, in fact, robust competition in every significant or insignificant market in this country. Seniors will have choices. They will have people competing for their business, and they will not only have better prices, but better service as a result.

Mr. LARSON. Unfortunately, the choices that they face currently are between heating and cooling their homes and the food that they have to put on the table and the expensive cost of prescription drugs. Let us hope that you are correct. Because for them, it is a God-awful decision.

Secretary LEAVITT. This is a great moment in history for us to be able to take that choice and put it into the past for many seniors.

Mr. LARSON. I hope you are correct.

Chairman THOMAS. I thank the gentleman. The gentleman from Colorado, Mr. Beauprez, wish to inquire?

Mr. BEAUPREZ. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for coming before us today. I would like to continue down the path my colleague just established a little bit, perhaps in a little different venue, but this Committee, and this Congress is wrestling with the rather weighty issue of Social Security, and if

we reform, how we reform, concern about the growing unfunded liability out in front of us, and as large as that is, as some of us look at the complexity of the rest of government, and specifically healthcare, it somewhat pales by comparison to the looming cost in front of us to challenges in front of us as to how in the world do we deal with at least the path of escalation that we have established for escalation of cost. From your perspective, which I would acknowledge is a reasonably powerful perspective, a well informed perspective, especially having been a Governor, how do we get our arms around that? What are the opportunities that exist in front of us to not only reach the edge of the cliff, but total off of it, which we would, of course, like to avoid?

Secretary LEAVITT. Congressman, that is a complex subject, but I would offer 2 points as a beginning. The first is the foundation, which is the use of information technology to transform the health sector. It is behind woefully, and it is beginning to challenge or to be a weight on our competitiveness as a nation. Once that is back in place, I see us moving toward a system that is focused on the consumer as opposed to organized to the convenience of the system itself. We need a system that will begin to respond to the consumer and allow direct access to the consumer, and then the capacity to tie it together with technology to where we have a system, very shortly, I believe, that can eliminate the inefficiency, for example, of a written prescription, where a person takes a piece of paper that they may or may not be able to read and takes it to a drugstore and waits for it to be filled.

I see a day very shortly where a doctor will be able to with a PDA write a prescription that will have been coordinated to the electronic health record of a patient, that before the patient leaves the physician's office, it will be being filled by a neighborhood pharmacy and deliverable either at their home or at their reach. That is the kind of inefficiency—and we have all experienced this. We don't have to explain this to each other. We all know that it is fundamentally inefficient, and that we have got to transform it, not simply tinker around the edges.

Mr. BEAUPREZ. It is my observation that if anywhere that old adage "time is money" is true, it is certainly true in healthcare. It has been called to my attention that as much as—in the most expensive point of delivery in healthcare in our entire system, emergency rooms, for an hour of patient time, we, and I use that very collectively, we, but a lot of it, the government, have burdened our healthcare providers with an hour of paperwork. It seems to me that maybe we have overdone what was probably a very good idea with excessive regulation.

I would offer you more as an observation than really a question, that perhaps we should be aggressively looking there as well, to try to wring some of the escalating costs, again assuming that time is money, the costs out of health care and let docs and nurses take care of patients. Last, in what little time I have—and maybe you have to respond in writing—you had mentioned that there is considerable savings with Medicare, and I believe I wrote it down correctly, intergovernmental transfers and other inappropriate actions. Can you respond with what exactly you meant by that?

Secretary LEAVITT. The President has indicated his belief that we should wrestle with three problems with Medicaid this year. In 26 seconds I will just tell you. The first is we are overpaying on prescription drugs. There is general agreement among the States and the Federal government on that point. The second is that there are loopholes in our law that have provided a means by which people could give their assets to their children and qualify for Medicaid. That needs to be changed. The third is that there are some honest disputes between States and the Federal government about who should pay what share. Those are called intergovernmental transfers. It would take a while to describe it. It is time to fix it.

Mr. BEAUPREZ. I thank the Secretary, and I yield back, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. Does the gentlewoman from Pennsylvania, Ms. Hart, wish to inquire?

Ms. HART. I do, Mr. Chairman. Thank you. First, Mr. Secretary, I want to thank you for the work you did in your prior position, especially with regard to the reason with which you approached a lot of questions that we work with you, and I expect the same—

Secretary LEAVITT. Thank you.

Ms. HART. In this position, although it is probably going to be a little more trying, I would imagine. also, I am interested in a lot of the same things that Congresswoman Johnson is interested in. She had mentioned something earlier about mental health clients. We actually identified some concerns at home for mental health clients moving from Medicaid to Medicare and some of the unique problems that they have and they face. I commend that to your Department, and I hope to work with you along with a couple of the national organizations that are advocates for people with mental health issues. I don't have a particular question about it right now, but I look forward to working with you.

Secretary LEAVITT. May I say that the conversation we have had today about mental health and this transition has raised questions in my mind that I want to further investigate, and I appreciate having the conversation. It has been stimulating to me in that respect.

Ms. HART. We will share some of the concerns that were brought up. I just had a meeting in the district on Monday about it. My main question, though, is regarding the Medicare Modernization Act, some of the things that I think are really wonderful as part of it. I know that as those who are getting their health care through Medicare will learn, that it is going to be really helpful to them, especially the preventative solutions to health care issues. Many experts believe, obviously, this is going to be helpful to the quality of life and therefore, obviously, the quality of their health for seniors and for others on Medicare. If we are proactive like this, as all the private plans really are becoming, health care costs could be confronted and reduced like never before. I know there has been a number of issues that have been identified by your agency about that. I would like it if you would spend a little bit of time speaking to those issues specifically as you view them as we begin to implement the new Medicare Modernization Act (P.L. 108-173).

Secretary LEAVITT. It would seem that many of those issues might be best responded to in writing so, that I can give you a con-

sidered response. As I understand your question, you would like to know how I basically feel with respect to mental health issues.

Ms. HART. No, not mental health. Just in general health issues for people on Medicare as a result of this preventative focus that Medicare will take as a result of the modernization.

Secretary LEAVITT. I think one of the great opportunities that has come about from the Medicare Modernization Act is the Welcome to Medicare physical. Not only will that provide a foundation for us to begin to treat those things that need to be healed, but it can also, provide us with a foundation of wellness. The transformation that needs to occur in our country is not simply providing technology for our records; it is a mindset. It is about not simply looking for ways to heal but for ways to keep us well. I envision a society where we have fewer people who are sick because more people have done things to prevent themselves from becoming ill. That is the opportunity that I think the Medicare Modernization Act sets forward for every senior as they enter, to have a wellness physical, a benchmark so, that we can begin not just to treat what ails them, but prevent those things that could ultimately shorten their life. I view the job the President has given me as the Secretary of Health and Human Services to fundamentally help people live longer and healthier lives, and to do it in a way that will help us maintain economic competitiveness as a nation. I think this is fundamental to that purpose.

Ms. HART. Aside from being a life-fulfilling sort of idea, as far as seniors being healthier as they age, do you also, see it as a cost-saving measure?

Secretary LEAVITT. No question about it. Not only will it be cost saving as we prevent it, but it also, provides great benefit to those who ultimately have longer lives and live better.

Ms. HART. Are there any estimates that the Department might have that might help us to discuss that when we are in our districts?

Secretary LEAVITT. I feel confident that there are. I am not able to articulate them, but I would be pleased to respond in writing. [The written response from Secretary Leavitt follows:]

We understand your questions to be addressing potential health benefits and cost savings related to the new Medicare preventive benefits enacted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As of January 1, 2005, all newly enrolled Medicare beneficiaries are covered for an initial preventive physical examination, all beneficiaries are covered for cardiovascular screening blood tests, and those at risk for diabetes are covered for diabetes screening tests.

These new benefits can be used to screen Medicare beneficiaries for many illnesses and conditions that, if caught early, can be treated and managed, and can result in far fewer serious health consequences. Such conditions as obesity, diabetes, heart disease, and asthma could be made far less severe for millions of Medicare beneficiaries.

For example, approximately 129 million U.S. adults are overweight or obese, which costs between \$69 billion to \$117 billion per year. Obesity also has a significant impact on Medicare beneficiaries' quality of life and on Medicare spending. For the period between 1996 and 1998, a 15 percent increase in annual per capita Medicare spending is attributable to being overweight, and a 37 percent increase is attributed to being obese (Finkelstein EA, Fiebelkorn IA, Wang G. "National medical spending attributable to overweight and obesity: how much, and who's paying?" Health Affairs-Web Exclusive. 2003 Project Hope).

- Additionally, in 2002, an estimated 20.8 million people (7.0 percent of the population) had diabetes, costing the U.S. approximately \$132 billion.
- Heart disease and stroke are the first and third leading causes of death in the United States. Cardiovascular diseases cost the U.S. more than \$300 billion each year.
- Approximately 23 million adults and 9 million children have been diagnosed with asthma at some point within their lifetime, with costs near \$14 billion per year.

By providing an initial physician examination for all newly enrolled Medicare beneficiaries, seniors and disabled Americans will have the opportunity to discuss with their physician the importance of preventive care and living a healthy lifestyle.

Smaller amounts might be spent preventing these conditions, given accumulating evidence that much of the morbidity and mortality associated with these chronic diseases may be preventable. Combined with other screening and preventive services already covered by Medicare, the MMA's new preventive benefits could result in Medicare spending less overall to treat beneficiaries with these conditions.

Ms. HART. I would be pleased to receive that. I think it is part of the measure that has been underdiscussed, and I do now know, as people are starting to understand, that there is this Welcome to Medicare physical. They are pretty excited about it, I know, people that are approaching that age. The other issue, of course, for them is just the opportunity to know up front, early, and not really seek treatment when they are really sick. Thank you. I yield back.

Chairman THOMAS. The Secretary, as a welcome to Washington informational piece, needs to know that the \$1 billion cost of the physical provided no savings under the cockamamie scoring structure under which we operate here. He will find that there are a number of issues that, as you settle in, you will realize that getting this place to focus more real world in terms of cause and effect will produce savings. I am pleased to say this Committee and this Congress accepted the cost, after 6 years, of getting the physical in place anyway because we know, even if it doesn't produce any real savings, quality of life will go up significantly, whatever price tag you may place on that. Does the gentleman from Illinois, Mr. Emanuel, wish to inquire? We go back and forth between the Democrats and the Republicans; and if there were another Democrat, I would call on them, but you are the only one here.

Mr. EMANUEL. I feel like a Member of the Agatha Christie novel, "And Then There Were None." So, I am here. Is cockamamie—can you find that in the dictionary?

Chairman THOMAS. Actually, that is HHS jargon.

Mr. EMANUEL. I would hate to break it up into separate—maybe we should give it to Mr. Safire, he has some free time. Thank you, Mr. Chairman. Thank you, Mr. Secretary, for being here, working with you at EPA. You know, I know I missed my colleague from Connecticut's question about obviously the issue of direct negotiation. I think one of the unfortunate—talked about a couple issues. One is on Medicare; second is on health care for children; and then on welfare. Hopefully I can get it in in short order. As your answers to periodic questions about the prescription drug bill and letting the market forces detail in that area and deal with price, the biggest issue as relates to seniors are prescription drugs—where it represents now 6 out of every 10 cents of dollars, or 60 cents out of every dollar that they spend is on prescription

drugs, where it used to be 10 cents—was the issue of affordability and price. I think the prescription drug bill missed dealing with that issue both in the areas of direct negotiation, reimportation, or moving generics to market quicker to compete against name drugs.

In every one of those areas you could use market forces correctly and tools from the marketplace to get lower prices. Every purchasing agent for any corporation uses bulk negotiation. That is how Sam's Clubs does it; that is how Lowe's does it. They force the competitors to make—and then because of purchasing power, use their bulk purchasing to drive down prices. Everybody on this side says, why doesn't the government copy the private sector? Here is one example we want to copy the private sector and we rule it out, and yet we could get savings for taxpayers and for senior citizens. Second is, you know about my passion for reimportation because here in the United States we pay 40 percent more than anybody else in the world. It may not be the cure-all, but it would be one way to dent and bring competition to bear in the marketplace. The third would be bringing generics to the market faster, not allowing frivolous lawsuits by pharmaceutical companies to keep generics off the market for a long period of time. Every one of those are proven marketplace tools to bring prices down.

Now, your predecessor—and you know, you have been asked here by others—would have liked to have that negotiating authority. You had it. Just in the prior question to my colleague from Colorado, you mentioned Medicaid pays too much for prescription drugs is one of the dictates by the President to deal with that. Medicaid can do certain things, Veterans Administration can do certain things, the purchasing agent at Sam's Clubs can do certain things, all leading to lower prices and getting the best price. We are preventing that from happening. I would hope at some point in your period of time here, rather than hiding behind the issue of safety—or we allow the insurance companies to do it—you can negotiate. I have full faith and credit that you can negotiate on behalf of 41 million purchasers of pharmaceutical products. So, I want to make that statement, because I don't think we are using the market correctly.

Second is, there was an article the other day, I think it was on Monday, in the Wall Street Journal about how many middle-class families have been letting their kids—rather than purchase the health care through their company because it is too expensive—to go into basically the SCHIP program. They are middle-class families. Have you ever looked at basically a consumption tax, a nickel, 4 cents, as a way to pay for universal health care for kids zero to 18, and make the commitment that for every kid zero to 18 we would pay for their health care? How much would that cost, and could we do a financing mechanism? I mean, I would be open to using a consumption tax on that basis to pay for health care for kids. Have you ever seen what would it cost to have universal health care up to 18 years old in this country? Do you have a cost estimate?

Secretary LEAVITT. I do not.

Mr. EMANUEL. Could it be something that the Department could look at?

[The written response from Secretary Leavitt follows:]

The MMA prohibits the federal government from interfering in the price negotiations between Part D plans and drug manufacturers and pharmacies. While the MMA does not allow government price negotiation, this does not mean that aggressive price negotiation will not take place. The MMA relies on private sector price negotiation and other cost management efforts to deliver substantial savings for beneficiaries. While some have called for the government to become directly involved in drug price negotiation under Medicare Part D, doing so would not save money and would have unintended adverse consequences.

Both CBO and the CMS Actuaries have concluded that allowing the government to negotiate drug prices would not generate additional savings under Medicare Part D. The MMA relies on health plans and their related PBMs to negotiate deep discounts with manufacturers and to manage costs through proven techniques. Both CBO and the CMS Actuaries believe these plans will be able to achieve 25 percent cost management savings over time and that beneficiaries will save in a competitive market by migrating to more cost-efficient plans with lower premiums.

Private sector price negotiation and other cost management activities have delivered substantial cost savings for other federal programs like the Federal Employees Health Benefits program (FEHBP). FEHBP leaves price negotiations up to the private plans that provide coverage for federal retirees. It has worked well for these plans, and we believe it will for Medicare as well. Enrollees in FEHBP plans have benefited from the favorable prices negotiated by these plans, likely resulting in lower out of pocket costs for copays and premiums.

In addition, price setting by a program as large as Medicare could be disruptive to the health care market. Medicare beneficiaries account for about 40 percent of the dollars spent on prescription drugs in the U.S. If Medicare undertakes a heavy-handed government approach to drug prices, the implications for the market could be large. While some government programs have had some success with mandated pricing, these programs are much smaller than Medicare, and their pricing strategies do not have as great an impact on the health care market. Price setting by a program as large as Medicare may not permit adequate investment in research and development that we need for the future.

We do not believe that Medicaid's approach to determining drug prices would generate larger savings than private sector efforts under the Medicare Part D program. While CMS data suggest that the Medicaid program receives rebates equal to about 22 percent of expenditures, the Medicaid program generally pays higher prices for brand drugs at the retail pharmacy than private insurers, which means that the ultimate prices paid by Medicaid are not as low as 22 percent rebates would suggest. The overall savings experienced by the FEHBP program from discounts, rebates, and cost management activities and the overall savings projected by CBO and CMS Actuaries under private Medicare Part D plans compares favorably to the Medicaid experience.

Due to differences in the circumstances under which the Department of Veteran's Affairs and Medicare provide drug coverage, we believe that the VA model would not generate additional savings for Medicare. The VA directly purchases and delivers drugs to many individuals, whereas the Medicare program offers beneficiaries a choice of private plans and pharmacies. Many of the prices for VA drugs are determined not by price negotiation, but instead by statutory requirements related to the federal supply schedule.

Experience with the Medicare Drug Discount Card Program suggests that private sector price negotiations have the potential to yield substantial cost savings for beneficiaries. The Medicare Drug Discount Card program has delivered substantially lower price for beneficiaries, and has done so without the leverage that an insured benefit will have. CMS estimates that the Medicare drug discount card program offers prices for brand name drugs that are about 12 to 22 percent lower than national retail cash prices, based on analysis of prices offered by card programs for 6 illustrative baskets of drugs. A private plan that administers a drug benefit is likely to have substantially more leverage in negotiating discounts and rebates than a discount card program. Thus, the success of the Medicare drug discount card sponsors in negotiating substantial discounts and rebates bodes well for the potential of Part D plans to meet our expectations of substantial cost savings for beneficiaries.

Secretary LEAVITT. I am sure that between the able budgeteers at CBO and with technical assistance from HHS we could perhaps assist—

Mr. EMANUEL. Get a price? Okay. To the issue of welfare reform, and having worked on it and worked with you when I was in the administration, one of the things that, besides child care, you know the Medicaid health care 1-year transition ends after the first year, and then a parent—as you ably show, one of the best benefits of welfare is to that child. Welfare reform that is. Because the person now working, that child is part of a culture of work. Yet, when that parent loses their health care, you are making them choose between work and being a good parent, and many times, as you know, the data shows people slip off of work and independence back into welfare, because that is the only way they can be a good parent and get the health care. I would hope that we look at in the proposal, of getting a second year of Medicaid transitional health care for people who leave welfare and go to work rather than just 1 year. It gives them a longer time in the workplace.

Chairman THOMAS. Does the gentleman from Ohio, Mr. Chocola, wish to inquire?

Mr. CHOCOLA. Indiana, Mr. Chairman. I would be happy to inquire. Thank you.

Chairman THOMAS. Would the gentleman yield just very briefly?

Mr. CHOCOLA. Sure.

Chairman THOMAS. Because, as new Members to the Committee, I would just tell the gentleman from Illinois that, as he knows, that the question of moving from patent drugs to generics is in fact in the jurisdiction of the Energy and Commerce Committee and not in this Committee's jurisdiction. In addition to that, in requesting CBO analysis of the Medicare modernization bill prior to its passage, the question was, were we to follow the Medicaid procedure of best price for drugs, that would cost us \$18 billion. The "to market" strategy employed in the Medicare modernization bill saved \$18 billion. The very point the Secretary made about saving money on Medicaid is, in fact, the use of best price, and their leaving money on the table that could be available through the market price structure. I thank the gentleman for yielding.

Mr. CHOCOLA. Thank you, Mr. Chairman. Thank you, Mr. Secretary, for being here, and thanks for your service. You might be able to surmise from where I am sitting in the Committee here and the order of the questioning here, I am new to the Committee. In fact, I am relatively new to Congress. Not long ago I was in the private sector. Unfortunately, I just caught the tail end of my colleague from Colorado's question, but I think he was asking you about information technology and the value of that. Certainly I would encourage you, having seen the magic of implementing information technology on productivity gains and lowering costs—improving quality, serving our customers better in the health care field I think could truly be magical if we can utilize that. So, I am glad to hear that you support that.

Part of my goal as a Member of Congress is to bring some business practices and procedures to Washington. One of the things that certainly perplexes me and disturbs me is OMB has reported, I think last year, up to \$45 billion of payments were made improperly and about 40 billion of that was in programs under the juris-

diction of this Committee. Certainly information technology can help us identify and prevent those. We talk about how much we spend on programs, and unfortunately our only measurement of success is how much we spend but not how well we spend. If we can identify those things and prevent those things, certainly we can spend much better. Do you have any thoughts now, or could you provide them later, on ways we could work together to make sure we prevent those improper payments in the future?

Secretary LEAVITT. Every morning when I wake up, health information technology implementation is on my mind for that very reason. I believe it is the transforming power to allow us to have a more efficient system, to maintain our competitiveness as a nation, to deliver health care to more, to reduce the number of mistakes that are made in health care, to provide lower costs and better care.

Mr. CHOCOLA. Well, I look forward to working with you and seeing ways we can accomplish that, because certainly I think it is very important. Just one quick other point. We have heard about questions about reimportation from places like Canada. One of the things that I never hear the other side of is the fact that the United States has about 50 percent of the drug market in the world; Canada has about 2 percent of the drug market in the world. It strikes me that we could reimport essentially every pill in Canada, and we could not really address the problems that we have here in the United States. It sounds like a good solution, but in fact it is not a very practical solution, because Canada simply does not have the supply. I think some of the leading pharmacies have come out and pointed that out, that they cannot fulfill America's drug needs. Do you have any thoughts on that?

Secretary LEAVITT. We have spent most of our time today in the brief interchanges we have had on this subject focused on the cost. I will just acknowledge the fact that there is a lot of dispute on the economics of that subject, and I won't further that discussion today. What we have not talked about is safety. Drug counterfeiting is real and it is serious and dangerous. We have no idea at times whether a drug is a counterfeit drug or whether it is a real drug. There could be substantial differences in the quality of that product. My predecessors have very clearly indicated that they did not believe we had the capacity to guarantee the safety of those pharmaceuticals. I am new at this job. I am only forming my own opinion, but I am very quickly coming to the realization that drug counterfeiting is real and dangerous.

Mr. CHOCOLA. Thank you, Mr. Secretary. Thank you, Mr. Chairman. I yield back.

Chairman THOMAS. I thank the gentleman. The Chair, for a very brief round of questioning, will recognize the gentleman from Washington, Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I appreciate that. One of the issues that we talked about briefly earlier was health care coverage in this country. You were talking about the tax credits. In the past, the administration has estimated that 60 percent of the people who participate in the tax-credit program would have been previously insured. In other words, they already have coverage, and for one reason or another they now start taking the

credit. Is that—does that really add to the—I mean, are you biting into the 44 million that don't have health insurance if what is happening is that 60 percent of the people who come into the—you say there is going to be 6 to 12 million, something like that. If you expect that 7 or 8 million of those are going to be people who already have insurance and just are simply taking advantage of the credit, or their employer is saying we are going to raise the cost because you can now get a credit, I mean, I can see the manipulations that will go on. Are you anticipating that will come out of the individual market people are buying for themselves or people who are in company-sponsored things?

Secretary LEAVITT. Congressman, I have spent considerable time in recent days working to reconcile what the number of uninsured individuals actually is, and I have discovered a rigorous debate that exists. You can hear numbers between 32 and 48 million, and you can hear them larger than that or smaller than that if you choose to understand their arguments. One thing I have concluded is that there are broad groups of that population who are receiving care, but we don't call them insured because they don't have a policy. The community health center system is a part of that. The Indian Health Service is also, an example of that.

It is equally difficult then to begin to estimate what the impact of one program or another will be on the permanent capacity for people who have health insurance. There are people who receive it, who give it up for various reasons at different times, and it is hard to come up with an exact number. What I have concluded through the advice of extraordinarily gifted people, economists, is that over the course of the next 10 years we can assist 12 to 14 million people to be among the rolls of those who are insured. I—

Mr. MCDERMOTT. Presently uninsured people?

Secretary LEAVITT. That is correct.

Mr. MCDERMOTT. With the indulgence of the Chairman, if you would give us the best of your analysis, because I think this issue will come up in this Committee.

Chairman THOMAS. It is an important question, and I think the Secretary should submit an analysis, especially focusing on—the gentleman's time has expired—focusing on the way in which people define the uninsured; because there are a number of people who are, for want of a better term, periodically uninsured, there are those who are chronically uninsured, and there are those who technically are uninsured, but, as the Secretary said, receive significant health care.

[The written response of Secretary Leavitt follows:]

The health insurance tax credit proposal will benefit up to 4.6 million Americans who would otherwise not have coverage. The health insurance tax credit proposal provides a subsidy for low-income individuals with modified income of less than \$30,000 and families with modified income of less than \$60,000. These eligible individuals and families have the option of using their tax credits to purchase a high deductible health plan (HDHP) and contribute to an HSA or to use their tax credits to purchase non-HSA eligible health coverage. The health care tax credit is only for lower-income individuals and families, who are unlikely to be eligible for subsidized employer-sponsored health insurance.

Additional information to respond to Chairman Thomas' question:

How the uninsured are measured is an important issue to consider. People can be uninsured for various reasons, such as being between jobs, out of school and no

longer covered by a parent's plan, not offered or ineligible for coverage through an employer, or not able to afford the coverage that is offered or available. In addition, a person can be covered for a relatively short time (between jobs) or for extended periods (unable to afford any coverage). The Agency for Health Care Research and Quality (AHRQ) has conducted analyses on data from the Medical Expenditure Panel Survey (MEPS) that provides some insight into some of these measures of the uninsured.

AHRQ indicates that 79.8 million people under age 65 were uninsured for at least one month during the two year period between 2001 and 2002, the most recent MEPS data available. Of this group, approximately 31% (24.6 million) were uninsured for at least two years (long-term uninsured).¹ But another 30% (24.0 million) of this group was uninsured for 6 months or less, while about 19% (15.0 million) were uninsured for 7 to 12 months and about 20% (16.1 million) were uninsured for 13 to 23 months.

While the Administration seeks to expand access to coverage for all those who are uninsured, clearly those who are chronically uninsured for the long term (two years or more) are of the greatest concern. These long-term uninsured are disproportionately older, poorer, and more likely to be Hispanic than those who are uninsured for shorter lengths of time.

Among all individuals, those between the ages of 18 and 24 have the highest rates of uninsurance and the highest rates of long-term uninsurance. Despite the high rates among younger individuals, older individuals make up a disproportionate share of the long-term uninsured, even with their low overall rates of uninsurance, with 40% of the uninsured between 55 and 64 years of age remaining uninsured for two years or more.

AHRQ analyses have shown that individuals below 200% of poverty are disproportionately represented among the long-term uninsured, even more so than among the total uninsured population. The poor (individuals below 200% of poverty), while comprising 12% of the total population, make up 19% of the total uninsured population and 21% of the long-term uninsured. Conversely, while high-income individuals make up 38% of the population, they make up 20% of the total uninsured and 16% of the long-term uninsured.

Hispanics have the highest overall rate of uninsurance and the highest probability of being uninsured long-term. Hispanics make up 15% of the population, but 24% of the total uninsured population and 36% of the long-term uninsured. Of the 53% of Hispanics that lacked health insurance at some point during the two-year period, almost half (24%) were uninsured for two years or more.

Chairman THOMAS. It is necessary for the Chair to note that, on the other side of the coin the gentleman just described, there are 40 percent of people who were not otherwise insured prior to the program who are now insured. The old adage of one size doesn't fit all is, I think, exactly right in this case. We are going to have to look at a number of not only legislative responses but, frankly, outreach programs to identify those folks to begin to bring them in. The Chair appreciates the concern of the gentleman from Washington and, frankly, wants to work with him in examining the current programs, how we can maximize the effectiveness of those, and look for some alternative programs; because, frankly, any number short of a technically correct 100 percent coverage isn't good enough.

Mr. MCDERMOTT. I think, Mr. Chairman, the reason I raise this issue, and I think the Governor knows and you know, that many States have tried to maximize their Medicaid coverage and they have played all kinds of interesting games to do that. What I am wondering about is the kind of shifting that will go on when we put a tax credit out there, what will be the effects of all that?

¹AHRQ defines the long-term uninsured as those survey respondents without health insurance for the entire two-year period they were surveyed. This population is compared against individuals who were uninsured for any length of time.

Anything you can do to give us an analysis of that would be very helpful.

Chairman THOMAS. Not just an analysis of the consequence, but some gaming as to how we can anticipate and therefore be ahead of the curve.

Secretary LEAVITT. Mr. Chairman, just a reminder, and I am sure all of you are aware of this. Those are administered through the Department of Treasury. We look forward to that kind of coordination and would be delighted to be part of a collaborative effort, but it is not specifically something within the mission or budget at HHS.

Chairman THOMAS. I would tell the gentleman how fortunate he is in appearing before the Committee that has direct jurisdiction and responsibility for the Department of the Treasury, and we look forward to inviting you to a coordinated effort in that regard.

Secretary LEAVITT. Thank you.

Chairman THOMAS. Without any additional questions, the Chair thanks his colleagues, the Committee stands adjourned.

[Whereupon, at 1:24 p.m., the hearing was adjourned.]

[Questions submitted by The Honorable Jerry Weller to Secretary Leavitt and his responses follow:]

Questions Submitted by Representative Weller

Question: Last year I engaged then HHS Secretary Thompson in a dialogue about rates of reimbursement for Federally Qualified Health Centers (FQHC) within the Medicare program. Specifically I had a concern that the per visit payment limit might be negatively impacting access to care, particularly among low income beneficiaries. In May of 2004 I received a letter from Secretary Thompson in which he shared my concern for ensuring access to care, although he believed the rates for FQHCs to be adequate. To his credit and because of the importance the President has placed on utilization of health centers, the Secretary did direct the Centers for Medicaid and Medicare Services (CMS) and the Health Resources and Services Administration (HRSA) to look into the FQHC payment limit, specifically how that limit was derived and whether it was appropriate to recalculate the limit.

Almost a year later, I am now getting word from health centers inside my district and my state that this issue is a "dead issue" within CMS and that there is no intent to pursue the issue any further. I am obviously dismayed; particularly since I had the word of the previous Secretary to look into this matter.

Secretary Leavitt may I have a commitment from you that you will pick up where your predecessor left off and direct CMS and HRSA to evaluate the FQHC payment limit and respond to my concern in writing to you?

Answer: As you know, the Federally Qualified Health Centers (FQHCs) are paid for their reasonable costs to treat Medicare beneficiaries, subject to a limit on a per-visit payment. For calendar year 2005, the per-visit payment limit is \$109.88 for FQHCs located in urban centers and \$94.48 for FQHCs in rural areas. The FQHCs can also bill separately for certain other services that are not included in the per-visit limit, such as x-rays, electrocardiograms, and clinical lab services. The FQHC per-visit limits have continued to be updated for increases in medical practice costs.

Expanding access to health care for medically underserved Americans continues to be an important priority for this Administration. The FQHCs serve a very important role in providing health care in rural and other underserved areas. I strongly share your concerns in ensuring accessible care in these areas. Federally Qualified Health Centers (FQHCs) provide primary care services and the current Medicare payment amount adequately reimburses for this care. Although we believe the payment cap is appropriate and reasonable, we will continue to monitor FQHC payment amounts to ensure that FQHCs are paid appropriately.

Question: One of the rarely discussed improvements coming out of the Medicare Modernization Act was the adjustments made to the Medicare FQHC program. It is my hope that changes made to the program will increase access to care for low income seniors at community health centers. In Illinois, only 4% of health center revenue is derived from Medicare and I think the adjustments will help improve that percentage in my state.

Relative to the adjustments made in the law:

Is CMS on target to implement the FQHC “wrap around” payment for services provided under the Medicare Advantage (MA) program? My understanding is that CMS plans on implementation in 2006.

I also understand that CMS is near completion of the regulations governing the FQHC Medicare program. When will they be available for comment?

Relative to Medicare Advantage, I am concerned that low income beneficiaries living in very poor rural and urban communities may not have access to services provided at health centers, particularly those low income beneficiaries who choose an MA plan. I understand there is little support for requiring MA plans to contract with FQHCs, but how does CMS intend to assure access to FQHC services through the MA program?

Answer: Medicare Advantage (MA) organizations must provide adequate access to services for enrollees and, before contracting with MA organizations, CMS conducts reviews to ensure that the network of providers is adequate to meet the health care needs of expected plan enrollees. MA organizations are free to contract with FQHCs but they are not required to do so. The Medicare law explicitly prevents CMS from mandating the entities with which MA organizations contract to provide services. In order to ensure that requirements for enrollee access to needed services are met, MA organizations are also able to request capacity limits on their enrollment if their network is not large enough to care for additional enrollees. Also note that changes to the Medicare law made in 2003 address certain financial considerations related to payment for services provided by FQHCs under contract with an MA organization. Specifically, the law established a wrap-around payment beginning in calendar year 2006 to make up for any shortfall between what an MA plan pays an FQHC under contract and the payments the FQHC would receive from the Medicare fee-for-service program for similar services. Note that the MA plan must pay the FQHC the same amount it pays other contracted providers for similar services. We believe this change in the law may help facilitate contracts between MA plans and FQHCs.

Question: In a recent paper released to explain the upward revision in the Medicare Part D cost estimate, the Centers for Medicare and Medicaid Services (CMS) referenced the implementation of competitive bidding for services as a step they are taking which will “provide a stronger foundation to keep Medicare sustainable.”

Assuming that access in rural areas and quality standards are protected, does the Administration support extending competitive bidding to additional items and services paid for by Medicare?

Answer: CMS is in the process of implementing a Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), as mandated by section 302 of the Medicare Modernization Act (MMA). This program is based in large part on a prior Medicare demonstration project, which obtained significant savings on DMEPOS items at the two demonstration sites.

MMA section 302 also requires a competitive bidding demonstration for clinical laboratory services. The CMS Office of Research, Development, and Information is now working on a clinical laboratory bidding implementation plan.

We expect the current DMEPOS bidding program and the clinical laboratory demonstration to offer insights into whether additional items may be good candidates for competitive bidding. Thus, we will look to the results of those programs to inform any future competitive bidding initiatives.

[Submissions for the record follow:]

Statement of Marlena Roberta Bryson, Canyon Country, California

Our 15yr old daughter went to a party without our permission and her father and I found out about it. She refused to let us know where she was, refused to come home because she knew she would be grounded and we had taken her computer

away. So we called the police and reported her as a runaway on December 17, 2004. We didn't hear from her for over 2 weeks. When we were finally notified of her whereabouts, it was by DCFS. Martin Tillinger notifies us that our daughter has been with her maternal grandmother (who we haven't spoken to in 6 months due to a family dispute, has made allegations of abuse by us and she is too afraid to come home. The next day, Martin comes to our home, does an investigation, interviews me and my three younger children, checks out our home and decides that our 15yr old daughter hasn't proven her allegations to be substantial and she was released back to us. Unfortunately, she was extremely mad and hit me with her fist in my left eye right in front of the DCFS office. I sustained a deep gash next to my eye that required stitches. At that time, Martin sent her to stay with her paternal grandparents. I did not press charges against my daughter. Martin proceeded to close the case on. On 1/13/2005, a different CSW Manjit Walia re-opened the case and on 1/14/2005 my three younger children were detained and taken out of school by DCFS. We were told that we were in violation of a previous dissolution custody order, which was in fact dismissed because my husband and I reconciled. Manjit assumed the order was still in affect. That same day, we meet with Manjit and Martin. We provide them with the notice of entry dismissal and proof of service that was filed in Ventura County. Then she says well 10 years ago there was a domestic violence issue and the all three younger children said that we were going to lock our 15 yr old daughter in her room, mind you, she has a bedroom window or bathroom window to sneak out of. So right away we knew Manjit wasn't being honest with us. These are bogus and false statements. She never once has come over to see our home. Our children were sent to live in a 2bdrm home with senior citizens (paternal grandparents), they sleep on the floor, they have been told that they are not wanted there, that only there 15yr old sister was the one they wanted to stay with them, they are threatened to get whipped with a belt and split up in different foster homes. Their paternal grandparents tried to tell us how to raise and reprimand our 15yr old and when we disagreed with them, they felt disrespected. That is when, I feel, they collaborated with the maternal grandmother(who has given them money during this time) get the kids away from us, because we haven't let her visit our children in over 6 months due to our dispute). Now, as of 1/20/2005, all 4 children were court ordered to temporarily stay with their paternal grandparents while the hearing was continued for further investigation. My 3 youngest cried out loud, as well as my husband and myself, in court. They want to come home with us. They told Manjit they wanted to come home. Even Martin told Manjit to let them go home to their parents. She refused. On 1/21/2005, my husband is notified that our 3 youngest children have run away from their grandparents. We eventually find them hiding in our back yard. On Monday 1/24/2005, reluctantly I had to return them to the Santa Clarita Sheriffs. At that time, I was arrested on felony parental abduction charges. I was booked and incarcerated for approx 23 hours. I wasn't read my rights until about an hour before I was released because the D.A. rejected my case. My children were sent to a foster home in Palmdale. I almost didn't make it to the emergency hearing on 1/27/2005. I was never notified by DCFS about the hearing or that I had a right to attend. It was only when the foster mother informed me of the hearing and that I had a right to be there. I attended that hearing and was given a monitored visit with my three youngest children. Even though the foster mother is very nice, my children are not happy there. My son was on a basketball team and has since been kicked off. My two girls are in Girl Scouts and are missing troop meetings and cookie sales. My youngest daughter was supposed to perform in a school play. Our family has goals in life. We are on a mission to do things in life. We have had our problems in the past. We are not perfect. We love our family very very much. My husband and I have been together for over 21 years and married approximately 16 years. Unfortunately, neither one of us had a good childhood upbringing. Therefore, we don't have a solid background of how normal families should be. So we are learning day by day. I do believe that has hindered us in living life on our own. I now understand the deep impact that has had on our family's lifestyle. We are not trying to make excuses for our actions—we are just acknowledging the facts that lead us to where we are today. Our kids know we love them as we know they love us. We are very involved in daily activities with them. My whole world surrounds my family. I am determined to do whatever it takes to get us back to the way we were. No matter what the paper trail appears to be, we are focused on our family. It is our family. We aren't cruel people. We are only human. We are open to suggestions for help with situations that we cannot maintain. We know we deserve an opportunity to help our family succeed and stay together. We don't deserve to be separated, without a chance to repair what has gone wrong. No one has given us chance to heal our problems. No one has stopped to even ask us if there's a problem or to offer advice. We're sorry for our wrong do-

ings. We are aware of our actions. We also are learning from them. Don't punish our family without at least giving us a chance to improve.

I have written a letter to several politicians, local, national and state agencies requesting information as well as help. Approximately 80% have replied with offers to help. Assemblyman Keith Richman's office is investigating DCFS on my behalf. I recently heard from Governor Schwarzenegger's office and they too are concerned with DCFS's actions against my family. I am so grateful to receive help from these officials. Now, that DCFS became aware of their involvement, they have change their position and have recommended our children be returned to us immediately.

I still believe that CPS/DCFS needs to be completely reformed. The CPS/DCFS agencies have been given too much authority/control over family's daily lifestyles. They have continued to violate civil rights and pass judgment without thorough investigations. Unfortunately, monetary incentives seem to be at the root of their intentions. They manipulate and sabotage every family they come in contact with. These agencies are staffed with the most corrupt rogue workers there are.

**Statement of Molly K. Olson, Center for Parental Responsibility,
Roseville, Minnesota**

Title IV-D—Welfare Reform—Budget Savings Idea

**Clarify that IV-D is Intended for the NEEDY not any Private Domestic
Relations Action**

State Agencies are Misusing Title IV-D to Obtain Federal Funding

**Is this a State Issue or a Federal Issue? State Legislators Need
Clarification.**

This written testimony is a **BUDGET SAVINGS IDEA** applicable to federal Title IV welfare reform, with a potential to save taxpayers nationwide as much as \$88 billion a year.

The Title IV-D program is unnecessarily costing taxpayers (federal, state, local) as much as \$88 billion in *direct* and *indirect* costs because of the misapplication of federal law resulting in an overreach of authority by the state's IV-D agency, *under the direction* of the Federal Office of Child Support Enforcement (OCSE), a division of the U.S. Department of Health and Human Services (DHHS), which take their instruction from Congress and the President.

Title IV-D of the Social Security Act is a federal program that states are mandated to implement if they voluntarily participate in and want federal funding for Title IV-A (TANF). Title IV-D is a federal program that is administered by the state or a local agency within the state. All Title IV programs are meant for the needy and most vulnerable families. We need to continue to protect this class and promote independence from government.

My concerns are particular to Minnesota, but the issues are identical in all other states that implement their IV-D program void of any eligibility standards and means testing.

ISSUE: The OCSE has directed the state IV-D agencies to exceed their authority through their unwarranted practices, which are contrary to congressional intent, defying the purpose of the Title IV program, and unnecessarily costing taxpayers billions. **This program must be restrained to protect the public purse and protect the privacy and independence of our families.** The program has become over-inclusive because of the misapplication of the law, creating an **excessive burden to the taxpayers.** The program is violating individual rights because of an unlawful overreach of IV-D authority into private domestic relations matters, which are reserved to the states. Absent a determination of financial need prior to approval of the IV-D application, there is no pecuniary or protectable interest for the government to provide Title IV-D services.

LAW/RULE: A change or clarification of the law or regulation, or a clarification to the states from the OSCE are needed to restore the program to its intended purpose and stop unwarranted government intrusion of the Title IV-D program into non-needy families nationwide. According to the congressional record Title IV-D requires:

1. First, Title IV as a whole, is limited to "needy" families who have become "**dependent**" on the government for financial support.
2. Title IV-D requires an "**absent parent**" and a "**needy** family." The congressional record indicates the definition of the term "absent parent," for the purpose of Title IV, includes those parents who were not at all involved with their

children, who abandoned the family to public assistance, and who are not fulfilling their responsibility to raise the children, thereby resulting in a “needy” family.

3. The congressional intent of Title IV–D clearly limits the class of IV–D recipients to two:
 - a. *those on welfare*, then IV–D becomes a **cost recovery** program, to save taxpayer money by collecting money through IV–D to reimburse the IV–A agency, and
 - b. *those at risk of falling on welfare (former and never welfare recipients)*, to protect those who would become “needy” if they don’t receive their support payment privately, to ensure payments as a **cost avoidance** measure.

Currently, loving, involved, responsible, regular paying non-custodial parents (good parents) are unnecessarily falling under the control of the government IV–D program even when their children are fully taken care of and at no risk of becoming part of a “needy” deprived family. Private domestic relations family matters are being unnecessarily drawn into the IV–D program even when: 1) there is no support problem and the non custodial parent has a history of consistently paying, and 2) the custodial parent (IV–D applicant) is financially well off (earning as much as \$100,000 a year) and has never been on public assistance, is not likely to ever need public assistance, and could afford to take care of all collection privately—so in effect, self-sufficient and even affluent people are using IV–D services because they get the services free or substantially subsidized by the taxpayer. State and local agencies encourage ALL divorced people to participate in the IV–D program regardless of need or circumstance, because the MORE people that are in the program, the MORE federal funding the state/local agency receives. The IV–D agency is growing on the backs of good people who have no need for the government program, but who are encouraged (even erroneously ordered) to use it, just because it is available. **Larger IV–D agencies may be good for the agency, but it is not good for our families**, and it does not promote efficient government.

Unfortunately, nationwide, the practices under IV–D have exceeded the law and defeat the purpose of the program, using scarce public resources to provide services to a class Congress did not intend to serve. Testimony, as far back as 1997, has warned of this problem created by perverse incentives to the states.

Responsible Public Servants Warned Congress of the Problem

Ms. Frye, Chief, Office of Child Support in CA

For the Welfare Reform Bill

3/20/97

She states:

*“As we understand it, the proposal goes far beyond the Congressional intent to develop an incentive system that rewards good outcomes and in fact **encourages** states to **recruit middle class families, never dependent on public assistance and never likely to be so, into their programs in order to maximize federal child support incentives**”.* She goes on to say, *“And my colleagues across the country have already informed me how I can **win at this system**; recruit the middle class, bring those higher orders into your system and that way you will be able to benefit like some of the other states from the cap removal on the never-welfare population”.*

As an “agent” of the federal government, for the purpose of delivering IV–D services, the Minnesota State Department of Human Services shows their misunderstanding of the program, as they falsely inform our state legislators and judicial officers that IV–D is an “entitlement” program. The MN DHS has also declared to the other branches of government that: 1) IV–D is a stand alone program, and 2) that the federal government requires the state to provide all the IV–D services to *anyone and everyone* who applies. The U.S. Supreme Court decision, *Blessing v Freestone*, made it clear that IV–D is NOT an “entitlement” program.

Title IV–D is NOT an “entitlement” Program

U.S. Supreme Court

Blessing v Freestone, 520 U.S. 329 (1997)

*“Title IV–D was not intended to benefit individual children and custodial parents, and therefore it **does not** constitute a federal right. **Far from creating an individual entitlement** to services, the standard is simply a yardstick for the Secretary to measure the system-wide performance of the State’s Title IV–D program. Thus, the Secretary must look to the aggregate services provided by the State, not whether the*

need of any particular person have been satisfied. . . . As such, it does not give rise to individual rights.”

The intended beneficiary of the IV-D program is not an individual, it is the government.

TITLE IV-D PROGRAM IMPLEMENTATION: The state and federal OCSE is misinterpreting 42 USC 654 (4)(A)(ii), and using the phrase “any other child” to swallow up every child in the country, when an IV-D application is filled out. Because of the federal incentives to the state, the local IV-D agencies are encouraging everyone to apply. Currently, there are only two criteria for an applicant to enter the IV-D program and receive IV-D services. In Minnesota and other states, the two step need determination assessment process for IV-D services is limited to: 1) did one parent fill out an application and sign it, and 2) are the two parents living in different households. Subsequently, even the upper middle class are being added to the program, absent a finding of financial need. There is nothing on the congressional record to support this over-inclusive eligibility standard—or lack thereof. Serving the affluent is contrary to congressional intent of Title IV and outside the scope of Title IV-D, which is to provide services to financially “needy” families only, which is clear limitation of all Title IV programs. This over-inclusive practice leads to a violation of many individual rights because the loving, involved, responsible, regular paying non-applicant parent is not provided an opportunity to object to the delivery of IV-D services in their private domestic relations case.

The IV-D program was designed to recapture money from legal “deadbeats,” not dads who involuntarily moved out, but relocated down the block so they could stay involved and see the children 3–4 days a week and maintain a strong record of regular support. However, once under the snares of the administrative IV-D agency, all non custodial parents find they have no individual rights and are assumed to be deadbeats, which increases conflict between the parents, which negatively impacts the children. The stated goal of the state IV-D system is to “maximize federal funding.” It’s not about the children. The system doesn’t have the best interest of children in mind, because the state is primarily after their own financial interest—that is, the federal funding. Loving, involved, responsible, regular paying dads do have their children’s best interest in mind, and these efforts are often thwarted and discounted by the IV-D agency. Many non-needy middle-class custodial parents ignorantly sign up for full IV-D services just for the wage-withholding service, because they are misled to do so by the local IV-D agency and told “IV-D is the easiest form of wage-withholding.” With modern technology, private domestic relations cases have many private banking options for wage-withholding and direct deposit, and all divorced people do not need the IV-D program.

The state IV-D agency and the federal OCSE are misinterpreting 42 USC 654(4)(A)(ii), 45 CFR 302.33, and 45 CFR 303.2 to mean the federal government requires the states to “provide” full IV-D services to *anyone* and *everyone* who applies regardless of need or circumstance. On its face, the regulation merely states the services “must be made available.” Clearly “made available” is very different than “provide.” A ballpark is “made available” to everyone, but that doesn’t mean everyone is “provided” entry on the day of a game or a seat of their choice, unless they meet certain requirements.

By allowing everyone and anyone into the IV-D program, when they simply fill out an application, **we are creating a welfare program for the affluent.** The IV-D program is **making self-sufficient people dependent on the government,** contrary to our welfare program objectives. This defies logic and common sense, and is unsupported by the record. (see attachment, with statement from GAO report).

Wade Horn, Assistant Secretary, Administration for Children and Families, U.S. DHHS provided testimony to the U.S. House Ways and Means Committee on February 10, 2005 (before the subcommittee on Human Resources). In his testimony, he indicated that the purpose of “these programs” (*referring to Title IV programs*) is “to improve the lives of **families who otherwise would become dependent on welfare.**” As many as 40–60% of all current IV-D cases nationwide would not be eligible for services using the congressional purpose to limit the program to applicants: 1) on welfare, and 2) at risk of falling on welfare. Mr. Horn further testified that the next steps are to make “**economic independence** within the reach of America’s **neediest families.**” People earning \$80,000–\$100,000 a year do not fit that focus or achieve the goals established by Congress for the IV-D program. Providing services to this class of people must stop or the whole system will eventually crash and go bankrupt (see attachment, with statement by former Secretary DHHS).

Congress may not be opposed to providing IV-D welfare service funding to the wealthy. However, if the states are opposed to this practice and want to limit IV-D services to the “needy,” consistent with congressional intent, it seems that Congress should make it clear that the states are allowed to limit IV-D services based on an assessment of “need” and be assured they can do this without being in violation of any federal law, regulation, or the State Plan.

Is this a federal question or a state question? The Minnesota Department of Human Services claims the authority to determine who is provided IV-D services is “a federal issue” further claiming “the feds make us do it” (i.e. provide IV-D to the wealthy families who are receiving their support with no problem, but apply for IV-D). If providing IV-D services to the non-needy and even affluent families is not a federal requirement, but rather, a choice the state can make or not make, and still be in compliance with IV-D, this must be made clear throughout the entire IV-D system nationwide.

CONCLUSION/SOLUTION/WHAT CONGRESS CAN DO: Minnesota citizens and state legislators want to change state law to clarify that IV-D services are limited to those “needy” families Congress intended to serve: 1) those on welfare, and 2) those at risk of falling on welfare if they don’t receive their private support payments. State taxpayers nationwide need to know the delivery of IV-D services must be limited to “needy” families. The MN DHS claims the **Federal government WILL NOT ALLOW MINNESOTA to limit IV-D services to needy families**, and that the state must provide services to everyone and anyone who applies. This means Minnesota (and all other states) are providing IV-D welfare services to the non-needy, who have never been on public assistance, display no evidence they are ever likely to need public assistance, and have never experienced a support collection problem. To provide clarity to the states, if this is not the position of Congress, please dispel the notion that the Secretary of DHHS can require that the states “must provide” services to the non-needy who are outside the scope of the purpose of the Title IV-D program and beyond the stated intent of Congress.

BOTTOM LINE: Minnesota has *wide bi-partisan support* for a *deficit reducing measure* that would limit the non-public assistance IV-D services to the “needy.” We are assured other states would follow. The Minnesota state legislative body is seeking documentation from the federal government that would ensure:

1) Minnesota will not be out of compliance with the Title IV-D State Plan or federal law, if we enacted a state law that would limit IV-D services as Congress intended to: 1) those on welfare, and 2) those at risk of falling on welfare if they didn’t receive their support privately.

Please help solve this problem of the over-reach of authority by the IV-D agency, resulting in unwarranted intrusion by the government, impacting the privacy rights of non-needy families, and causing an *excess burden to taxpayers* at all levels: federal, state, and local. I represent a 100% volunteer organization, and we have no paid lobbyists, and “we the people” need your help. We have been seeking an answer from Congress on this issue for more than two years; 201 Minnesota legislators are waiting for a response. The awareness of this misapplication of the IV-D program is spreading over the internet and emails are being forwarded nationwide to expose the problem.

WE WANT OUR FAMILY ATONOMY BACK. We expect fiscal responsibility with our tax dollars. Congress and federal and state agencies are charged with the task of allocating limited funds across a range of needy families. Private domestic relations matters should remain private absent a compelling state interest. When there is no pecuniary interest for the government, nor a need to invoke *parens patriae* powers to protect the child, the government should not be involved in the family. Putting loving, involved, responsible, regular paying non-custodial parents and high earning custodial parents into the Title IV-D program unnecessarily increases conflict, destroys what little is left of the fractured family, thereby harming children, and is nothing short of a fraud upon the taxpayer. We have 7 people on our research team with 38 years of cumulative experience researching Title IV-D. We would appreciate the opportunity to share more of our research with you, and answer any questions at anytime.

The GAO has already figured out this problem.

Why has this report has been largely ignored?

June 13, 1995 "Opportunity to Reduce Federal and State Costs"

Report # GAO/T-HEHS-95-181

By Jane L. Ross, Director, Income Security Issues

" . . . many non-AFDC clients may not be within the population the Congress envisioned serving." p. 6

According to the Bureau of Census 1991 data, "about 65% of these reported incomes, excluding any child support received, exceeding 150% of the federal poverty level." p. 6

" . . . about 45 percent reported incomes exceeding 200 percent of the poverty level and 27% reported incomes exceeding 300 percent." p. 6

" . . . the rate at which child support services are being subsidized appear inappropriate for a population that Congress may not have originally envisioned serving." p. 5-6

"The non-AFDC child support program—many are not within the low-income population to which Congress envisioned providing child support enforcement services." p. 3

The US DHHS has made a strong policy statement

Why has OSCE policy changed to require that a full range of services be provided to all applicants?

U.S. Supreme Court Case—Blessing v Freestone, 520 U.S. 329 (1997)

Silver's Reply Brief (page 5) to the Eleventh Circuit Court

Policy Statement From Donna Shalala, US Secretary DHHS:

" . . . a guarantee . . . of the full range of . . . child support enforcement services—for all individual cases—would bankrupt IV-D agencies across the country."

Submission of Tammy Lee O'Dell, Mesa, Arizona

I am writing on behalf of my sister and her problems with CPS. I feel that CPS is wrong in so many ways. After telling my sister she must come up with clean UA's she would get her baby (2months) back and they wouldn't come get her other 2 children whom are 3 and 5 yrs. old. After doing UA's for 3 months they showed up at her door with an officer and forcefully took her 3 yr. old little girl from her arms claiming they already picked up her 5 yr. son from school. They reason they gave was because she was living at a house they told her she couldn't stay at. If that was the case why did they go where she actually was. At the next mediation they said that they were not going to give the baby back because he has been in the care of the grandmother and is use to her. They would schedule supervised visits and them not bring her children for 3 months. Her 5yr. old son thinks his mom doesn't want him. CPS want to know why her son has so much anger built up not remembering they could be that reason. For the 3 months my sister did not see her children they told her it was because she never called her parent aide the day before and my sister said she hasn't been able to get ahold of her. It just so happened on the same day my sister shows up to see her children which they weren't there, CPS tells my sister that they haven't been able to get ahold of her parent aide for 2 weeks. Cps has made up stories in her file that are not true. Things like she had a baby die in California which she has never lived or been in California. I remember the very first mediation she had with all the CPS workers and her lawyer and we told her lawyer that she wanted to fight the grandmother who took the baby from her. We tried to explain that the grandmother has been after my sister since the day she refused to not do the abortion in which the grandmother was gonna pay for. She even wrote a letter to my sister begging to adopt the baby and continued until after he was born. My sister refused. When she told her lawyer that she wanted to fight the grandmother he said ok. But when we got into the court room that is not what happened. He told the judge that she agreed to do the parent assessment program. And since you cant say anything in court to the judge and that fact that we really didn't know what was going on until afterwards and he explained it to us and thought that would be for the best we were very angry.

I tried writing to the ombudsman office but all I get from them is we will look into it and that's as far as it goes. My sister may lose her parental right to her baby and other children if something isn't done. And that would be what ever game CPS would like to play and by their rules. Either way I fear she may lose. I have tried myself to take care of the children and they once told my other sister that they (CPS) would do what ever it takes to see that these children do not go to any member of this family. I really don't know how these so called child protectors can go into a happy home remove children and wonder why these children are so mentally and emotionally a wreck. They should look into the mirror and quit blaming the parents. I really hope that if nothing else I can care for these children, they can grow up with their own family members and not be bounced from one home to another. I leave you with this to think about, what if it was your own child taken from you, not knowing where he or she was cause they wont tell you. Wondering is he being taken care of. I pray for all of those parents whom are innocent.

Statement of Chris P. Nelling, Mercersburg, Pennsylvania

We have read with interest about The Committee on Ways and Means Hearing on President's Fiscal Year 2006 Budget for the U.S. Department of Health and Human Services and would like to add our point of view. We are joining the growing community which believes our tax funds would be put to better use helping preserve families rather than tearing them apart. Although organizations like Child Protective Services and U.S. Department of Health and Human Services claim they are protecting children by removing them from abusive homes, a recent study suggested that over 85% of children in foster care have not been abused by their biological family. (See Shell, Susanne. 2001. *Profane Justice*. Sage Wisdom Press). In most instances the children are taken from their families without a trial, hearing or even due process because if any of these rights (which are supposed to be guaranteed by our Constitution) had been granted to the family then the state would surely lost their bid to remove the children. We would like to share with you our case.

Cumberland County Children and Youth took four of our five children in May of 2004 (they first started trying in Spring of 2003), based on accusations that they completely made up. They placed two of the children with their biological father "Mark" and two in a foster home. At the first hearing (where they took the children) we did not have documentation to contradict what they testified to since we had not been informed of the accusations at that time. Children and Youth's lawyer had several months to prepare their case against us, we met our lawyer about 10 minutes before the hearing. After the first hearing, when we learned about the accusations we knew we could get physical documentation (medical and court records) to disprove the allegations. During the time we were preparing our case against CCCY, the case worker told us that Mark no longer wanted the two children placed with him, but he did not want them to go back to Charolette either. Mark and CCCY told us that if Charolette agreed to let four children get adopted, they would drop the case against our youngest daughter. We were having trouble with our court appointed lawyer at the time (he was supposed to a court appointed "free" lawyer for those who can not afford one, but he kept implying that we should be giving him money, so we agreed.

During one visit in August, one of the children "Gabby" told Charolette that Jeff was hurting her and Jeff was touching her. Charolette asked the caseworker who Jeff is and he turned out to be the foster mother's biological son. The case worker also informed Charolette that Gabby had killed Jeff's cat (she has never harmed animals before). Charolette asked for this to be investigated but CCCY denied the need for an investigation. Gabby repeated her accusations at the next visit, Charolette again asked for an investigation and was again denied. After the second consecutive visit where Gabby informed her mother that someone at the foster home was hurting her, CCCY started cancelling visits with the biological mother (once because the phone system there supposedly quit working, once because the children supposedly had the flu and once for an undetermined reason). After the third cancelled visit we received a family service plan to review and it contained a line that said "no further visits to be scheduled with the biological mother." Charolette continued asking CCCY to investigate the accusations against Jeff.

Charolette did not sign the adoption papers because she was unsure that the children were going to a safe place. We then started working on our case again because CCCY decided to try to terminate Charolette's parental rights. At the second and third hearings we had the documentation (outlined below) to show that their allega-

tions against us were false, but the master of the hearing would not allow us to read or show them because CCCY did not think it was appropriate.

ALLEGATION.	DOCUMENT.
1 Charolette denied medical treatment to Ashley (oldest daughter) on 04/30/04 and 05/05/05	Hospital records from not only those two dates but a third as well that clearly state Biological mother wants treatment, biological father denies.
2 Charolette has a history of child abuse and Mark does not	Charolette passed child abuse clearance Search that same year. Police record of Mark's arrest for abuse (in 1997). Report from Meadows Psychiatric Treatment Center stating Mark has abused wife and children.
3 Charolette was apathetic towards Ashley's disability (she has Tourette's Syndrom)	Charolette fought for safety belts on Ashley's bus at school. Charolette initiating The treatment at The Meadows and at Chambersburg and Carlisle Hospitals (see References above). Mark was not present At any of the safety belt hearings and opposed the hospital treatments.
4 CCCY has had previous founded cases against Charolette in which she admitted guilt.	Letter from previous case stating "assessment complete, unfounded, no services required".
5 Charolette was uncooperative towards Family Based Services (one of Ashley's treatment/care organizations) and did not attempt to meet the FBS goals.	Report from FBS dated 4/1/04 (one month before children were taken) listing 7 long term goals, 4 were completed, 2 approaching Completion and one in progress.

Again, we had these physical documents there and were not allowed to show them or read from them. After the hearings, we were congratulated for "winning" the case because they failed to terminate Charolette's parental rights. We did not feel like we had won, however, because we still did not have our children back.

Less than a week after the last hearing (Nov 10), we received a letter stating that after play therapy, Gabby has decided it was not Jeff who hurt her, but rather it was Chris. So after three and a half months of living with Jeff's mother and without any contact with us, when the child changes the name from Jeff (who was never investigated) to Chris, Chris had to undergo an investigation including police questioning. When the questioning began the officer started out using the term molested and on one occasion, rape. When Chris told them that "Gabby" had been seen by a doctor just a few weeks before she was taken from us and that he would testify that there were no signs of abuse then . . . the officer looked at the CCY caseworker, she nodded her head and the officer turned back to Chris and said "We have decided to reduce the accusation from molestation to inappropriate touching" or in other words from something that we could prove Chris didn't do to something that is impossible to prove either way. Chris requested a lie detector test which they said he could take by the third week of December and when they failed to make an appointment for that and I again requested the chance to take one they avoided the question and changed the subject. It is now almost March and Chris still has not had a chance to do this. In the second week of February, we received a letter informing us that the case against Chris is founded and his name is being added to the sexual predators list. This has been done without a trial, without a hearing or even without a chance to present his case with a lawyer present.

We know this is not an isolated incident. When we were in the waiting room before one of the hearings, a girl "Julie" came up to Chris. She recognized him from the store he owned at the time and started talking. Eventually she said she wished she could see her mom and step-dad and Chris asked if they had done something to her and if that was why she couldn't see them. She replied that she told them over and over that her step-dad "Mike" didn't do what they were asking but they kept asking so finally she said yes so that they would just stop. An older woman that was with the girl (we aren't sure if she was a caseworker or foster parent) just sat there smiling, like she was pretending not to hear.

We agree with the need to stop child abuse, but we do not believe U.S. Department of Health and Human Services actually contributes to stopping abuse. In many cases, such as ours, they even contribute to the abuse done to children. We believe that funds should be used to protect families, not destroy them. Children and Youth investigations concentrate on the poorer populations in society because the organization knows that these families can not afford a lawyer on their own and the court appointed lawyer will have no chance after being familiar with the case

for only a few minutes. In most cases, the parents are not even made aware of who the representing attorney will be or even what the actual charges are until just before the hearing. How can a family defend itself this way? Funds would be better appropriated in such a way as to give innocent families a chance to defend themselves against false accusations. Use funds to make sure the court appointed family lawyer has time to prepare a case. Use funds to help families provide day care for their children so they can get better educated or find jobs. Do not use funds to support the taking of children from innocent families and handing them over to true abusers. The recent election showed that America's top priority now is the preservation of family rights and values; lets not fund organizations that are trying to erode those values.

Statement of Roberta Lynn Reightley, Tehachapi, California

I am writing this on behalf of my granddaughters Evinee and Desiree Romero, who are twins. They were born on 9/15/04. They were born premature by emergency c-section to my daughter Virginia Romero. Her toxicology report was positive for meth and marijuana. Needless to say C.P.S. got involved. My daughter stated that she would like either myself or my oldest son and his wife to gain custody, while speaking with the hospital social worker, and I am a witness to this matter because I was in the hospital room visiting with her when the hospital social worker came in to interview her. Yet this is not what happened. They didn't fully investigate the family before they made their decision to place them in the home of pre-approved foster adopt parents.

The twins were in the hospital for almost two months, and the foster parents were visiting with the twins before they even left the hospital. The youngest twin Desiree left the hospital the day before our first court date, and the oldest twin Evinee left about a week and a half later.

I was about to take my very first vacation, yet the twins birth changed my plans and I stayed in the valley, I reside in Tehachapi, which is about an hour and 45min away.

For about the first month and a half, I was at the hospital participating in their lives, bathing, changing, and feeding them, I would hold them, talk to them, pray for them, I went out and bought them clothes and blankets. After I returned to work I visited as often as possible. My daughter had a set of bands and I had the other which would allowus to visit with the twins, I would take the family so they would be able to visit.

Our first day in court we addressed the court with letters of recommendation that I obtained from Law Enforcement Officers, Prison Officials, and others in the community, in which I reside, and we also offered my oldest son and his wife as an alternative for placement of my granddaughters. The attorney that I have spent over seven thousand dollars on then file a defacto parent application, and I also received a call from a supervisor at social services who had received the letters of recommendation, Nancy Patt who apologized and said that she was going to let me have the twins. I don't know the date of the call, yet for the next court date she wrote a excellent report on my behalf and told me to take the car seats with me, the date 11/8/04, the judge ordered a home assessment, that came back with a triple a rating. I didn't have parents who cared to raise me and I was put in the streets at 11, I was almost 12 years old and I went through so much and I didn't have a good background, yet who I am today should have made the difference, the courts were coming against me for things I was never convicted of and then they hade me jumping hoops stating you have three felonies and two would be acceptable so I had one expunged, I did everything they asked me to do. And for the next hearing which was the defacto parent application Nancy Patt wrote another good report in hopes that I would obtain custody of my granddaughters. Minors counsel who was a social worker turned attorney stated that the letters I had obtained were letters from my druggy friends I did not catch this comment my attorney did, I had a full drug screen that was witnessed that I paid for done it came back clean to all drugs yet, minors counsel stated that the stress of raising my granddaughters would put me back on drugs. I was clean for eight year and went through a situation with my oldest son, I lapsed for a period of three months and I have been clean and serving the Lord ever since, my son and his family is doing the same. The defacto parent application was denied at this present time but the doors were left open as my attorney stated that we would file for a pardon. Visits had been ordered from the first day in court and I have been driving 147 miles one way every week. I called my daughter in-law and I stated I am tired of playing their games, and asked her and

my son to go down and get live scanned my daughter in-law has made numerous calls to social services before this, they went down to the social services office and were live scanned. When the results of the life scan came back they were told they could be approved in twenty minutes because my son only had misdemeanors on his record and they were almost 8 years old. Yet they got a call back stating that family preference had been closed and I know for a fact it had not been closed. My daughter in-law called the fifth district and spoke with a person named Rene Quinn and she was then referred to a woman named Shirley Logan, my daughter-in-law Pam Romero explained the situation to Shirley who in return stated that something was not right and she would have this investigated, and they would get back to her within 10 days. Pam had to call her back because they had not returned her call within the ten days, Pam then received a call from a supervisor named Alberto Marro who stated that he looked through the court minutes and that family preference was never ruled on and that something was not right, and he could not understand why this had happened but that he would further investigate the situation and get back to her. He called her back and stated he had no answers for us, Pam then called Shirley Logan back who stated that It was out of their hands because it was already in the court system.

We appeared in court, myself my daughter my son and my daughter in-law on 1/25/05 in dept 114 and my attorney had prepared a document pertaining to my son Eloy and my daughter in-law Pam the Judge stated the she was not going to reopen family preference, yet this had never been closed, they were going off of Rod Loudens report to the courts who is against the family getting the twins. The judge did order that we all were able to visit each of us were granted one hour a week, and my daughter was granted two hour visits, the judge was informed that we had already been denied one visit so she ordered a make up visit. Which still has not been granted in fact I was denied two more visits. I called Rod Loudens pertaining to the first visit that was denied, he leaves the foster mom in charge of all visits, and when I called him this first time after court he stated, you are calling me why, I spoke to him in regards to the visit that was denied and he stated that if it were up to him family preference would have already been taken away and that we wouldn't have any visits at all. And he told me that there was nothing he could do about it. My daughter in-law Pam and I went and spoke to another Attorney who we retained, and he suggested that since my last visit was denied to call the socialworker directly to set up the visit, I did call Rod Loudens to try and set up the next visit I first called and left a message and he did not call me back, so I called again and he answered the phone, I said hi Rod this is Roberta he very sarcastically replied Roberta, Roberta who, I replied Roberta Reightley his reply was oh well you didn't leave your last name or a phone number when you left your message so I didn't know who you were and that is why I didn't call you back, I deal with 200 people a day, yet he knew who I was without stating I had left a message. I asked if he could set up my visit for this week, he asked did you call the foster mom, I replied no I am calling you because my last visit was denied and I would like to see the twins this week, he said he would call the foster mom and call me back, and he stated by the way the higher ups the people you called are investigating the case, he was very sarcastic with me almost to the point of being rude. He called me back and he said the foster mom told you that you and your family were supposed to get together and all visit on the same day for one hour, and I told him we had discussed this and it would be impossible, due to our different schedules and I had already change my days off at work to accommodate the foster mom's original requested days which were Mon. or Tues. and that I have been visiting on Tues. since we started the court ordered visits. He told me call the foster mom and discuss this with her. I did so and was denied this visit as well. We did set up a visit for the following Tues. I called Rod back and told him that this visit was also denied and that I won't be able to see them until next Tues. his reply was, well it will just have to be next Tues. then.

My attorney called and spoke with Ms. Johnson the day of court 1/25/05 due to the first missed visit and she assured my attorney that Rod would now set up the visits and that the foster parents would no longer be the monitors when it came to the visits. Ms. Johnson also stated that my daughter would be the only way we would be able to get the twins back into the family. The foster mom is still in charge of the visits they are also not in compliance with the court orders, and the foster mom has made false accusations against us stating that we have intimidated her, this same day we had previously had set up the visit for this day and the foster parents were in court with us this day, the social worker Rod Loudens had told them to go to court because, he was hoping and had told my daughter in-law that after this court date that all visits for the family would stop. The foster mom was in the courtroom when the judge made her ruling about the visits and that we were owed

a visit for the missed visit, yet when we met for our visit that day my daughter was with us and the foster mom would not allow a two hour visit.

We have continued to fight this matter any way we know how we've made more phone calls to Los Angeles county, we've called human resources who referred us to social services, who referred us to child services and they have told us that this does not sound right and that they would investigate the situation, I feel that there is something very wrong about this whole situation, they are keeping things under lock and key. They would not allow my daughter to look at her file, I took her to the court house to look at her file, they told her that the file was confidential and that she would have to write to the judge in order to be able to get any information from her file. We then called her attorney who didn't return the call until a week later, the attorney stated that if she had I.D. she should have been able to view her file, and asked why did she want her file that she had already told her what she needed to do.

I feel there is something very wrong about this whole situation, we have spent almost 15 thousand dollars on attorney fees and furniture because they told us we had to have everything prepared in our homes. I feel that there have been games played throughout this whole situation, and there are two precious lives at stake here who deserve to be raised in the house of the Lord and raised in the ways of the Lord.

Statement of Bob Moore, The Oklahoma Taxpayer, Lawton, Oklahoma

Freedom from Federal Personal Income Tax

President Bush's Inaugural Speech was about FREEDOM. Below are some ways the federal government can create more freedom for the American people.

I was telling a small group of friends about my Eight Year Plan when one lady spoke up to say, "Bob, you do not understand, the Federal Government is not into SIMPLE". I had to agree. I am into SIMPLE. I use the "KIS Theory" Keep It Simple.

First example of SIMPLE is the federal income tax on interest earned on bank accounts. Why have income tax laws for 300 million people when the federal government should have the financial institutions (appr. 10,000) pay a monthly tax being a percentage of the total dollars paid as interest to clients. No tax due from the citizens, the bank pays the tax, SIMPLE.

Same is true with stock dividends, have the corporations pay the government a percentage of the dollar amount paid to the stockholders. No tax due from the citizens, the corporations pay the tax, SIMPLE.

Second example, most taxpayers believe there is at least 2% waste in the federal government. If the President reduced the size of government by only 1.25% each year. That would be $8 \times 1.25 = 10\%$ totally reduction in the size of government at the end of eight years. That is a huge 10% savings, just that SIMPLE.

Third example of SIMPLE is the 40-40 Tax on Gasoline. As a child, I asked where does the .9 of a cent go? Years later, I still don't really know. Keep the tax simple and honest such as:

- a. eliminate the .9 cent;
- b. this tax shall not be amended for forty (40) years;
- c. a total tax of forty (40) cents a gallon tax according to the following:
- d. twenty (20) cents shall go to the federal government and
- e. twenty (20) cents shall go to the originating State government
- f. gasoline tax to ONLY go toward roads and bridges.

Fourth example of SIMPLE: Toll Roads, Sales Tax and Income Tax

Can you image driving up to the toll booth to pay the toll and the person starts asking you financial questions such as how much money do you make; how many children do you have; how many cars do you own. Then says according to your credits and deductions; the toll will be X dollars.

Next event, you visit Wal-Mart, when you check out, the Cashier starts asking you financial questions to figure out the amount of sales tax you will be charged.

Does this sound silly? Can you image how many people this type of tax system would require? How much un-necessary work this would cause?

Now look at the Federal Income Tax System with all the forms, credits and deductions, etc.

See the comparison? How simple the Federal Income Tax System could be with a flat tax. Our citizens live in fear of the IRS and hate April 15th.

There is a better simpler system available if people will demand it. With the follow system, we could eliminate the dreaded April 15th deadline.

Simple Tax System: Use the right formula then adjust spending to the amount of money collected. Truthful Tax Reform—Federal Tax Payroll Deduction Program.

1. "TOTALLY" Eliminate the Personal Income Tax "TOTALLY".
2. Fact: FICA tax is over 15% of the employees' paycheck. Federal Courts have ruled the FICA is a tax not a retirement fund. The Federal Government needs to be honest and declare that FICA tax goes to the general fund to pay for government spending programs. Re-name FICA tax to Federal Tax Payroll Deduction Program.
3. Government taxes should be on commission, just like all private businesses and private business' employees. The government spending can only grow if more people make more money.
4. Payroll deduction is the most efficient way to collect taxes. The Federal Tax Payroll Deduction Program will be the only federal tax that wage-earning Americans will pay. Never a personal income tax form to file with the IRS.
5. Keep the system simple, one rate for all taxpayers. Ten (10%) Percent is good enough for GOD, then Ten (10%) Percent should be good enough for the government. However the federal government is not as efficient as GOD so lets put the maximum rate at twenty (20%) percent. The Federal Tax Payroll Deduction Program shall be 20% "Maximum" of which Ten (10%) Percent to be withheld from the wage-earners' pay to be matched by Ten (10%) Percent from the Employer. Rate shall not be raised for Fifty (50) years.
6. Earmark how the money shall be allocated, such as:
 - a. 2% to Citizens Retirement Fund, a 401K type program—private social security fund for each person;
 - b. 4% to Social Security Fund for Senior Citizens retirement only;
 - c. 1% Senior Citizens Medical Fund;
 - d. 1% Disability Fund;
 - e. 1% Family Dependent Fund;
 - f. 1% National Defense; and
 - g. 10% for the other spending programs.

A total of 20% of the wage-earners' salary to go to the Federal government.

*** Would be great if each State Government would "totally" eliminate State Personal Income Tax to be replaced by receiving one (1%) percent of this 20% total.

This type of system would result in no forms, no worry and a much smaller I.R.S. No tax forms to file each year. No tax credits to be given or taken away by the Federal government. No increase or decrease in the tax rate.

This would get the Federal Government out of micro-managing the daily life of the taxpayers. It is called FREEDOM!

Social Security; at this point, the government should just pay everyone the same amount each month once the person has reached age 62 or 65. Yes I would increase the monthly check for everyone.

An advantage given by the government to one person means an unfair disadvantage to all other Americans. Our Founding Fathers believed that small government and less taxes means more freedom.

