

**HEARING ON THE PRESIDENT'S FISCAL YEAR
2008 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 TENTH CONGRESS

FIRST SESSION

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FEBRUARY 8, 2007
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**HEARING ON THE PRESIDENT'S FISCAL YEAR
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HEALTH AND HUMAN SERVICES**

THURSDAY, FEBRUARY 8, 2007

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

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

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 01, 2007
FC-8

CONTACT: (202) 225-1721

Chairman Rangel Announces a Hearing on the President's Fiscal Year 2008 Budget for the U.S. Department of Health and Human Services

House Ways and Means Committee Chairman Charles B. Rangel today announced the Committee will hold a hearing on President Bush's budget proposals for fiscal year 2008 for the U.S. Department of Health and Human Services. The hearing will take place on Thursday, February 8, 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 limited to the invited witness, 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.

FOCUS OF THE HEARING:

On February 5, 2007, President George W. Bush will submit his fiscal year 2008 budget to Congress. The budget will detail his tax, spending and policy proposals for the coming year, including his proposed budget for the Department of Health and Human Services. Many of the Department's programs -- such as Medicare, efforts to assist those who lack health insurance, and Temporary Assistance for Needy Families and other income security efforts -- are within the Committee's jurisdiction.

In announcing the hearing, Chairman Rangel said, "Congress and the Administration must work together to improve access to affordable, reliable health care and ensure income security for all Americans. I welcome Secretary Leavitt before the Committee and look forward to his views on these critical issues."

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 "110th Congress" from the menu entitled, "Committee Hearings" (<http://waysandmeans.house.gov/Hearings.asp?congress=110>). 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, February 22, 2007**. 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.

Chairman RANGEL. Mr. Secretary, we are so awed and pleased by your presence that we really are trying to get organized. We recognize that you have one of the most overwhelming responsibilities in dealing with an issue that is as important to the nation, certainly, as the war.

I can't over-emphasize the fact that Mr. McCrery and I still want to believe that it is possible for this Committee to tackle some of the most controversial subjects that are facing the nation and the Congress. We would like to do this with some help from the Administration. We may have our political differences, but we both believe that the problem is serious enough for us to do everything possible to try to find a bipartisan solution.

I am very pleased with the tone of bipartisanship that has been set by the Administration, but I find very little substance in terms of giving us help—excuse me, please. I had better check my policy, my health policy.

I thought, and you may disagree, that the President's State of the Union missed an opportunity to talk about areas that we could actually work in with bipartisanship. He sought, however, to bypass that. Then I thought perhaps if your office and others would have worked with our health Subcommittee, that we could have found out whether the President could have put something in here that would have indicated a way that we could have worked out some differences and agreed on some things.

But just as private accounts emphasize the President's feeling about Social Security, it appears as though this budget message to

us that we should cut Medicare by \$76 billion over 5 years and \$250 billion over ten, and to protect the HMOs, these type of messages cause us to believe that the Administration truly is trying to eliminate entitlements, whether they are Social Security, Medicaid and block grants, or Medicare, and effectively says, if you don't like my plan, you come up with your plan, rather than seeing whether we can come up with our plan.

I hope in the course of your remarks that you will share with this Committee what role, if any, you think the Federal Government should play, as opposed to the private sector, in providing the maximum benefits of good health care, at the same time trying to cap the soaring increasing costs of health care. We believe that rather than being annoyed by things that we resent politically, that we still have an obligation to work with you, and we look forward to that.

I will be yielding my time to Mr. Stark. But since it is down to almost nothing, I think I will recognize Mr. McCrery first.

Mr. MCCRERY. Thank you, Mr. Chairman. Welcome, Secretary Leavitt. I want to thank you for two things: number one, for all the attention you have paid to the plight of New Orleans in trying to rebuild its health care infrastructure following Hurricanes Katrina and Rita. Your efforts have been above and beyond what anyone could have expected from the Secretary of HHS at the Federal level. So, I want to thank you very much for your attention to those problems in the New Orleans area, and for your continued attention to those issues.

Second, I want to thank you for playing a role in developing the President's budget in the area of health care, and for putting forth not a radical idea, not a new idea, but an idea that hasn't been discussed very much in the last few years, and that is your standard deduction for health care, which basically takes the health insurance out of the workplace into the hands of individuals, and more fairly distributes the tax benefits that are currently in the Code under the tax exclusion for employees for health care.

As I have told you before, and others in the Administration, I think it is a very modest proposal. It doesn't go far enough, but it is a step in the right direction. At least it gets us talking here in the Congress about a concept that I think has a lot of merit, particularly as we are searching for ways to come up with funding to cover the uninsured in this country. So, thank you for both of those things, and I look forward to your testimony.

Mr. Chairman, I have a more lengthy statement I would submit for the record, and ask unanimous consent to have that included in the record.

[The prepared statement of Mr. McCrery follows:]

**Statement of The Honorable Jim McCrery, a
Representative from the State of Louisiana**

Yesterday, we heard from OMB Director Rob Portman about the financial challenges facing the Medicare program. Director Portman also described the proposals in the President's budget that are intended to address some of these issues.

We must deal with the challenges facing Medicare, and I believe these proposals are an important first step. I fear, however, that they do not do enough to secure the long term stability of this important program.

I hope, Mr. Chairman, that we can work together with the Secretary to make the changes to the Medicare program that are necessary to improve the program, address the rising costs, and protect beneficiaries' access to care.

I also want to take the opportunity to thank you, Mr. Secretary, for raising the issue of the uninsured. There are approximately 47 million Americans who lack health insurance today.

Our current health insurance system rewards the wealthy, penalizes the poor and discriminates against workers solely upon the basis of where they work. This makes little sense, given the demands of our 21st century economy, and I believe we need to develop a better system to provide health insurance for all Americans.

For much of my tenure in Congress, I have tried to find a solution to this growing problem. I have had some successful talks in previous Congresses with some of my Democratic colleagues, and came very close to developing a workable compromise. Unfortunately, it has always seemed as though the political climate just wasn't quite right.

Mr. Secretary, the climate seems to be changing. In recent days, newspapers across America are filled with stories about new proposals to cover the uninsured. Governors, both Democrats and Republicans, are introducing innovative ideas to address health care because they recognize that the current system isn't working.

The changes proposed by President Bush in his State of the Union Address are a good starting point for these discussions. I am pleased that the Administration has chosen to concentrate on the issue of the uninsured by addressing the inequities in our current tax system. By leveling the playing field and offering tax relief to Americans who purchase health insurance in the private market, we can lower costs and improve access to affordable health insurance.

I do not agree with all of the aspects of the President's proposal. In fact, I would do several things differently. However, I applaud the President and Secretary Leavitt for starting what will hopefully be a vigorous and thoughtful debate.

In closing, let me also say that I believe that any reforms we enact need to give individuals more control over their health care choices. The current system mandates that we take what we get, whether we need it or want it. Personal choices in the healthcare marketplace will lead to smarter consumer decisions regarding preventative care and help to reduce the rapid growth in national spending on healthcare.

Chairman RANGEL. Without objection.

I would ask unanimous consent that Mr. Stark and Mr. Camp be given an opportunity to address themselves.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. Welcome, Mr. Secretary.

I am going to quote an astute health economist, Uve Reinhardt, who said that a budget is essentially a letter to God. It is a listing of your priorities based on your core beliefs. It is clear from the President's budget that our core beliefs are very different, particularly in the health care and social services arena.

You have cut some \$300 billion out of Medicare and Medicaid over the next decade. Probably another 15 billion out of a much smaller budget for social services. It is all cuts. Just cuts. There is no place in the budget where we increase spending on Medicare, and this money, this 300 billion, obviously just leaves Medicare and goes to fund the war in Iraq or some other useless idea.

The budget not only maintains but hastens the provisions of the Medicare Modernization Act, which was designed to privatize Medicare. There is no mistake that the Republican goal is to change Medicare from a defined benefit that seniors can count on and turn it into a defined contribution. But that won't take care of seniors and people with disabilities and health care needs.

Your budget speeds up the impact of MMA, the part B income-related premium provision, and expands that policy to Part D. Well-to-do beneficiaries who already pay more for Medicare through the tax system, the most progressive tax—or regressive tax, I suppose; they pay more, they get \$10 million in income, they

pay the same tax and they get the same benefit as somebody at a minimum wage. To double up on them to me is only to turn them against the support, modest though it is, that we have had for the Medicare system.

That is Medicare. I have not even begun to discuss the so-called health reform proposal that the President puts down which would undermine the employer-based system which 160 million Americans get their insurance from now. That plan would give a low-wage worker basically a voucher worth 1100, and give those of us who are Members of Congress a voucher worth about \$6300. If that is equity, so be it. It also lowers Social Security benefits by about one-third for low income workers. Again, that doesn't seem to me to be something that we should be doing in this budget.

I can't neglect under-funding the State Children's Health Insurance Program. The President spends \$3.7 billion more for health savings accounts, which only go to the rich or benefit the rich, and he cuts 12 billion that is needed in SCHIP. He doesn't cut it, but he refuses to fund it, which is the bare minimum to maintain the coverage for those children who are in it today.

We get then to the welfare issues. Child care funding has been frozen, and this will result in 300,000 fewer children receiving assistance by 2010. This is in addition to the 150,000 children who have lost day care funding since 2000.

We have frozen Head Start at 100 million less than the House-passed joint continuing resolution called for. We have got low income energy assistance, and it is cold out here today; I don't know what it is like it Oregon. But that is a \$379 million decrease, mostly for poor, elderly people in the areas that are the coldest in this country.

The social services block grant that pays for Meals on Wheels, Child Protective Services, disability services, has had a \$500 million reduction. Now all we have got left is the most obscene grant to the Republicans, \$28 million for abstinence education.

That all goes to the Republicans, Mr. Secretary. Look at us, we are so ugly nobody would say yes to us. It is all these handsome Republicans that we have to train women to say no to. So, we have given the 28 million to them, and I think we had better rethink that.

I will look forward to more comments with you later.

Chairman RANGEL. Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman. I think I want to say thank you to Mr. Stark, but I am not sure.

Mr. Secretary, thank you for being here. I just want to say finding health insurance for people who don't have it I think is a goal that everyone on this Committee shares. I know you have been an outspoken advocate of reforming our health care system to make it easier for individuals without health insurance to buy it. There are a number of states taking the lead in this, and there are some policies in the President's budget.

Could you please elaborate on those for us and the Committee?

Chairman RANGEL. Well, this is not a question.

Mr. CAMP. Oh, all right. I am sorry.

Chairman RANGEL. This is a statement.

Mr. CAMP. Thank you. Well, I will look forward to that when we get to that time. Thank you very much. I will yield back.

Chairman RANGEL. Mr. Secretary, we anxiously await your report.

**STATEMENT OF MICHAEL O. LEAVITT, SECRETARY,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Secretary LEAVITT. Mr. Chairman, thank you. I have been thinking as I listened to your opening comments that it might be appropriate for me to set aside my prepared remarks and ask for you to adopt them into the record. Then I would like to respond to your invitation to talk a little bit about the way I feel, and I believe the way the Administration feels, about Medicare and other important safety net programs. Would that be appropriate?

Chairman RANGEL. Without objection, Mr. Secretary.

Secretary LEAVITT. Mr. Chairman, we are a compassionate nation. I think one very good indication of that is a widely held aspiration that every person in this country have access to an affordable basic insurance policy. If a person is elderly or poor, if they are disabled, if you are a mother who is low income and expecting a baby, if you are a child needing protection, we have as a country made a commitment that they will be cared for, and that we will provide them with health insurance and we will pay for most of it.

We do that through Medicare and Medicaid and SCHIP. They are very important programs to us. They form the underpinnings of our social safety net. I believe Americans, and I am among them, feel a sense of appreciation for the fact that we have those.

I sit before you today not simply as the Secretary of Health and Human Services, but with that duty comes the duty to be a trustee of those very important programs. Multiple times each year, I sit as a trustee and publicly pronounce the fact that the health of these very important programs is not what it needs to be. I believe there is an important need for all of us to be, in part, a physician to assure that they continue to be healthy.

The budget that we have put forward is often—or is being looked at as an amputation. The reality is we are looking at ways to provide weight loss, to keep healthy. I hope that through the course of the day, we will have a chance to talk about the individual proposals that we have to stir the conversation about how we can keep these programs healthy.

If we were to implement all of the ideas that we put forward in this budget, it would reduce the growth rate of Medicare from 6.5 percent to 5.6. There is no question that it would slow the growth. But all of them combined would still only preserve the sustainability of Medicare as a trust fund from 2018 to 2022. These are not cuts. These are intended to be ways of finding efficiencies, finding the best solutions to some problems that will allow us to sustain this.

Now, I would like to continue on this line by indicating that in the area of health care, it is the aspiration of the President, it is my aspiration, and I believe a widely held aspiration of the American people that every person have an affordable basic insurance plan. I have indicated that those who are neediest are cared for

through our safety nets. There are still others who have need, 47 million who do not.

I am currently working with some 18 states, and I suspect there will be other states, who are putting proposals together to solve this problem in their state. However, there are some dilemmas that they alone cannot solve.

In speaking with one Governor, he said to me, my problem is best typified by the person who works as a school aide but doesn't have enough hours to get benefits, and is married to a construction worker. The two of them make about \$60,000 a year, but they can't—they don't get health insurance from their employer.

So, in order to get it, they have to buy health insurance individually. They have to go to an individual market, and it is more expensive. Not only is it more expensive, but they have to pay their taxes before they can buy health insurance. As the Governor said to me, it is too heavy a lift. They just can't make it. We need the Federal Government to help us solve that problem so that I can provide an affordable basic policy to every person in my state. So, the President has put forward a proposal that would solve that dilemma.

Now, in addition to that, it is very clear to us that many in states across this country will still not be able to afford even a basic insurance policy. For that reason, the President has proposed that the Federal Government use Federal funds to help states close that affordability gap. Therefore, we would be able to meet the aspiration of an affordable basic plan for every person.

I hope that gives you a sense of what is in my heart as well as what is in our mind.

[The prepared statement of Secretary Leavitt follows:]

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

Chairman Rangel and Congressman McCrery, thank you for the invitation to discuss the Department of Health and Human Services' budget proposal for fiscal year 2008.

For the past 6 years, this Administration has worked hard to make America a healthier, safer and more compassionate nation. Today, we look forward to building on our past successes as we plan for a hopeful future.

The President and I have set out an aggressive, yet responsible, budget that defines an optimistic agenda for the upcoming fiscal year. This budget reflects our commitment to bringing affordable health care to all Americans, protecting our nation against public health threats, advancing medical research, and serving our citizens with compassion while maintaining sensible stewardship of their tax dollars.

To support those goals, President Bush proposes total outlays of nearly \$700 billion for Health and Human Services. That is an increase of more than \$28 billion from 2007, or more than 4 percent. This funding level includes \$67.6 billion in discretionary spending.

For 2008, our budget reflects sound financial stewardship that will put us on a solid path toward the President's new goal to achieve a balanced budget by 2012.

I will be frank with you. There will never be enough money to satisfy all wants and needs, and we had to make some tough choices.

We take seriously our responsibility to make decisions that reflect our highest priorities and have the highest pay-off potential. We recognize that others may have a different view, and there are those who will assume that any reduction signals a lack of caring. But reducing or ending a program does not imply an absence of compassion. We have a duty to the taxpayers to manage their money in the way that will benefit America the most.

I would like to spend the next several minutes highlighting some of the key programs and initiatives that will take us down the road to a healthier and safer nation.

Transforming the Health Care System

Helping the Uninsured

- The President has laid out a bold path to strengthen our health care system by emphasizing the importance of quality, expanded access, and increasing efficiencies.
- **The President's Affordable Choices Initiative will help States make basic private health insurance available and will provide additional help to Americans who cannot afford insurance or who have persistently high medical expenses.**
- **It moves us away from a centralized system of Federal subsidies; and,**
- **It allows States to develop innovative approaches to expanding basic health coverage tailored to their populations.**
- The President's plan to reform the tax code with a standard deduction (\$15,000 for families; \$7,500 for individuals) for health insurance will make coverage more affordable, allowing more Americans to purchase insurance coverage.

Value-driven Health Care

- The Budget provides funds to accelerate the movement toward personalized medicine, in order to provide the best treatment and prevention for each patient, based on highly-individualized information.
- It provides \$15 million for expanding efforts in personalized medicine using information technology to link clinical care with research to improve health care quality while lowering costs; and,
- It will expand the number of Ambulatory Quality Alliance Pilots from 18 sites in FY 2008.

Health IT

- The President's budget proposes \$118 million for the Office of the National Coordinator for Health Information Technology to keep us on track to have personal electronic health records for most Americans by 2014 by supporting our efforts to:
 - Implement agreed upon public-private health data standards.
 - Initiate projects in up to twelve communities based on recommendations of the American Health Information Community. These projects will demonstrate the value of widespread availability and access of reliable and interoperable health information.
 - Develop the Partnership for Health and Care Improvement, a new, permanent non-governmental entity to effect a sustainable transition from the AHIC.

Addressing the Fiscal Challenge of Entitlement Growth

The single largest challenge we face is the unsustainable growth in entitlement programs such as Medicare and Medicaid. The Administration is committed to strengthening the long-term fiscal position of Medicare and Medicaid and to moderating the growth of entitlement spending. The FY2008 Budget begins to address Medicare and Medicaid entitlement spending growth by proposing a package of reforms to promote efficiency, encourage beneficiary responsibility, and strengthen program integrity.

Medicaid

Medicaid is a critical program that delivers compassionate care to more than 50 million Americans who cannot afford it. In 2008 we expect total Federal Medicaid outlays to be \$204 billion, a \$12 billion increase over last year.

The Deficit Reduction Act (DRA) that President Bush signed into law last year has already transformed the Medicaid program. The DRA reduced Medicaid fraud and abuse and also instituted valuable tools for States to reform their Medicaid programs to resemble the private sector.

In FY 2008, we are also proposing a series of legislative and administrative changes that will result in a combined savings of \$25.3 billion over the next 5 years, which will keep Medicaid up to date and sustainable in the years to come. Even

with these changes, Medicaid spending will continue to grow on average more than 7 percent per year over the next 5 years.

Along with the fiscally responsible steps we are taking with Medicaid, we are following the same values in modernizing Medicare.

Medicare

Gross funding for Medicare benefits, which will help 44.6 million Americans, is expected to be nearly \$454 billion in FY 2008, an increase of \$28 billion over the previous year.

In its first year, the Medicare prescription drug benefit has been an unparalleled success. On average, beneficiaries are saving more than \$1,200 annually when compared to not having drug coverage, and more than 75 percent of enrollees are satisfied with their coverage. Because of competition and aggressive negotiating, payments to plans over the next 10 years will be \$113 billion lower than projected last summer.

We also plan a series of legislative reforms to strengthen the long-term viability of Medicare that will save \$66 billion over 5 years and slow the program's growth rate over that time period from 6.5 percent to 5.6 percent.

Similarly, we are proposing a host of administrative reforms to strengthen program integrity; improving efficiency and productivity; and reduce waste, fraud and abuse—all of which will save another \$10 billion over the next 5 years.

Promoting Health and Preventing Illness

We are also taking steps in other ways to transform our health care system. Helping people stay healthy longer also helps to reduce our nation's burden of health care costs. The President's budget will:

- Fund \$17 million for CDC's Adolescent Health Promotion Initiative to empower young people to take responsibility for their personal health.
- Strengthen FDA's drug safety efforts and modernize the way we review drugs to ensure patients are confident the drugs they take are safe and effective.
- Enhance FDA and CDC programs to keep our food supply one of the safest in the world by improving our systems to prevent, detect and respond to outbreaks of food borne illness; and,
- Include \$87 million to increase the capacity for the review of generic drugs applications at the FDA and increase access to cheaper generic drugs for American consumers.

Providing Health Care to Those in Need

SCHIP expires at the end of FY 2007 and the President's budget proposes to reauthorize SCHIP for five more years, to increase the program's allotments by about \$5 billion over that time, to refocus the program on low-income uninsured children, and to target SCHIP funds more efficiently to States with the most need.

The President's budget proposes nearly \$2 billion to fund health center sites, including sites in high poverty counties. In FY 2008, these sites will serve more than 16 million people.

We propose increasing the budget of the Indian Health Service to provide health support of federally recognized tribes to over \$4.1 billion, which will help an estimated 1.9 million eligible American Indians and Alaskan Natives next year.

We are also proposing nearly \$3 billion to support the health care needs of those living with HIV/AIDS and to expand HIV/AIDS testing programs nationwide.

In addition, we are requesting that Congress fund \$25 million in FY 2008 for treating the illnesses of the heroic first responders at the World Trade Center.

Protecting the Nation Against Threats

We must continue our efforts to prepare to respond to bioterrorism and an influenza pandemic.

Some may have become complacent in the time that has passed since the anthrax-laced letters were delivered in 2001, but we have not. Others may have become complacent because a flu pandemic has not yet emerged, but we have not.

- The President's budget calls for nearly \$4.3 billion for bioterrorism spending.
- In addition, we are requesting a \$139 million in funding to expand, train and exercise medical emergency teams to respond to a real or potential threat.
- Our budget requests \$870 million to continue funding the President's Plan to prepare against an influenza pandemic. The budget requests funding to in-

- crease vaccine production capacity and stockpiling; buy additional antivirals; develop rapid diagnostic tests; and enhance our rapid response capabilities.
- In FY 2008, the Advanced Research and Development program is requested within the Office of the Assistant Secretary for Preparedness and Response (ASPR). Total funding of \$189 million will improve the coordination of development, manufacturing, and acquisition of chemical, biological, radiological, or nuclear (CBRN) Medical Countermeasures (MCM).

Advancing Medical Research

The research sponsored by NIH has led to dramatic reductions in death and disease. New opportunities are on the horizon, and we intend to seize them by requesting \$28.9 billion for NIH.

Our proposal in FY 2008 will allow NIH to fund nearly 10,200 new and competing research grants, continue to support innovative, crosscutting research through the Roadmap for Medical Research, and support talented scientists in biomedical research.

Protecting Life, Family and Human Dignity

Our budget request would fund \$884 million in activities to help those trying to escape the cycle of substance abuse; children who are victims of abuse and neglect; those who seek permanent, supportive families through adoption from foster care; and the thousands of refugees that come to our country in the hopes of a better life.

Our budget request also includes \$ 1.3 billion to help millions of elderly individuals and their family caregivers to remain healthy and independent in their own homes and communities for as long as possible, including the \$28 million for our Choice for Independence initiative that will help states create more cost-effective and consumer-driven systems of long-term care.

Improving the Human Condition Around the World

If we are to improve the health of our own people, we must reach out to help other nations to improve the health of people throughout the world.

Our budget requests \$2 million to launch a new Latin America Health initiative to develop and train a cadre of community health care workers who can bring much needed medical care to rural areas of Central America.

CDC and NIH will continue to work internationally to reduce illness and death from a myriad of diseases, and in so doing will support the President's Malaria Initiative; the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria; and the President's Emergency Plan for AIDS Relief.

These are just some of the highlights of our budget proposal. Both the President and I believe that we have crafted a strong, fiscally responsible budget at a challenging time for the federal government, with the need to further strengthen the economy and continue to protect the homeland.

We look forward to working with Congress, States, the medical community, and all Americans as we work to carry out the initiatives President Bush is proposing to build a healthier, safer and stronger America.

Now, I will be happy to take a few questions.

Chairman RANGEL. Well, Mr. Secretary, it certainly does. But we have to be concerned as to what is in the beneficiary's mind, what is in the provider's mind, and we have to believe that the Administration did contact the hospitals and the doctors and the nurses and those that have a higher degree of obligation to take care of the nation's poor and sick and disabled.

You are not a politician. We are, but we all are public officials. We can come up with these mechanical mathematical solutions. But at the end of the day, if the people you are trying to help believe that you are trying to hurt them, then we have an obligation to try to do better.

It is for those reasons that I would think that in the future, you take into consideration what we have to do politically to take care of our constituents. Whether you agree with us or not, there are 435 of us over here that have to do the best we can.

We are going to try to work together without the Administration. But it sure would be helpful if we knew, and if the nation knew, that we have sharp political differences, and the patients and the people of the United States are not going to fall between the cracks because of political differences. So, we are just starting, and I hope it works out. I would like to yield to Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Secretary Leavitt, please take my 5 minutes, and if you would, explain in detail the President's proposal in the budget for the standard health care deduction and how it is different from what people get today in terms of a subsidy for their health insurance.

Secretary LEAVITT. Thank you, Mr. McCrery. I would like to begin by putting it into this context: It is our aspiration to provide every person in America with access to an affordable basic insurance policy. That requires that we as a Federal Government, working with the states, devise, as we have, programs that will care for those who are elderly and poor and disabled, those who are children needing protection. We do that through Medicare and Medicaid and through our SCHIP program.

Our aspiration would be then for every state to assure that there is a basic plan that is affordable to the citizens of each state. As I indicated, I could go around and each of you have Governors who are working on various methods of doing that.

However, there are two problems they are not able to solve on their own, and one is the problem that Mr. McCrery references. Currently, if a family—I will use the same example. You have a person who is working in a day care center married to a construction worker. Neither of them have access to a health insurance plan through their employer. But they need health insurance. They desire to have it. If they need to buy it, they have to then go to some outlet and buy it on their own.

Inherently, insurance today that a person purchases in the "individual market," that is to say, not through an employer, it is more expensive because of various problems in pooling their risk with other people. So, they start off paying more money than people who in fact buy it through an employer.

But then they have another serious problem, and that is that they have to pay their taxes before they are able to pay their insurance premium. That wouldn't be true for any of you or for me because we have our insurance provided through our employment, and as a result, we get a tax break.

They don't get it. Now, frankly, it is indefensible for one group of our citizens to get a tax break for the purchase of insurance and for another group not to. So the President's proposal essentially says, we are going to give everyone the same tax advantage for having insurance. If you buy a basic insurance policy, we are going to give a family \$15,000 as a standard exclusion. If you are an individual, you would get \$7,500.

So, the couple I have spoken of, the person who works in the day care center and a construction worker, now have a \$15,000 deduction in the same way that they would if they were working as an employee receiving insurance. As for the employer, they are treated exactly the same under this arrangement as they would otherwise.

Our effort here has been to create equity, to level the playingfield, to provide the same advantage for those who buy it through an employer and those who don't. It is a critical part of being able to assure that every person can have an affordable basic insurance policy.

Mr. MCCRERY. So, in other words, Secretary Leavitt, the employer could continue to provide health insurance through the workplace to the employees. The employer would continue to get a deduction for the expenses of the employer in providing that health insurance.

The employee, though, would not get a tax exclusion for the exact value of the provision of the health insurance from the employer. Instead, every employee, every person, would get a standard deduction of \$15,000 per family or \$7500 per individual. Is that correct?

Secretary LEAVITT. That is correct. I might add, Mr. McCrery, that this proposal not only maintains the status quo for employers, it would benefit 80 percent of those who purchase health insurance through their employer and 100 percent of those who have no health insurance at all.

This is a very progressive tax policy. You have characterized it as timid, but it is a very progressive, and I might say important, step forward.

Mr. MCCRERY. It is a very progressive step forward. It does not go far enough, in my view. I would put the cap much lower, frankly, to bring more awareness to individuals of the true cost of health insurance and health care. But it is a step in the right direction. It does provide much more equity in our tax expenditures than is currently present in the tax system. Thank you for explaining that.

Chairman RANGEL. Mr. Stark may inquire.

Mr. STARK. Mr. Secretary, I am not completely sure. But you have a definition of a basic insurance policy, and in it you have a minimum deductible for a family of \$2200. Is that not correct?

Secretary LEAVITT. It would be our view that the definition of what is basic should be determined by the state as well as what—the definition of affordability.

Mr. STARK. I am sorry. But this is in your own information that you have issued. You have suggested that the minimum annual deductible to qualify should be \$2200. Now—

Secretary LEAVITT. I believe that was established as an illustration. Our policy would be to have the states make the determination as to how they define "basic" and how they define "affordable."

Mr. STARK. So you are not going to federally define a benefit?

Secretary LEAVITT. We believe that it is—

Mr. STARK. Just yes or no: You are not going to define federally a basic benefit?

Secretary LEAVITT. We believe—while there may be some guidelines, we believe the states should define it.

Mr. STARK. You are going to give people money and then let the states decide what qualifies it?

Secretary LEAVITT. We believe there should be a basic requirement for states.

Mr. STARK. That is great. I mean—

Secretary LEAVITT. That they should determine within that how the benefits are—

Mr. STARK. Oh boy, oh boy, oh boy. Now, one other thing. Yesterday Portman was here, and your budget proposes 76 billion in Medicare cuts over five, 250 billion over ten. There is—they all come from fee-for-service providers.

Yesterday again Mr. Portman said he was unaware of MedPAC's recommendation to pay Medicare Advantage plans the same as fee-for-service, which would save 50 billion. Also, your own Office of the Inspector General on page 22 of the Red Book says that the Medicare Advantage plans are overpaid by at least \$3½ billion a year.

Why were those savings not taken and why were all the savings taken out of fee-for-service?

Secretary LEAVITT. We believe that Medicare Advantage is about integrating care, and that there will be efficiency and better quality—

Mr. STARK. Do you have any proof of that?

Secretary LEAVITT. Oh, I think we have—

Mr. STARK. Or is that a faith-based issue?

Secretary LEAVITT. No, no. We have—I think it is unquestioned that integrated care provides higher quality and patient—

Mr. STARK. You can't prove that, and you have no figures to show that, and you are costing more money on these Medicare Advantage plans, and yet you take all the money out of fee-for-service. Sounds to me like the for-profit plans that have been making huge campaign contributions have basically gotten to you.

Now, one other question. In this faith-based nonsense, you spend \$126 million, and yet the GAO has reported that it may be illegal, and you are not estimating whether they are doing any good. Is there some point when you intend to study the effectiveness of these plans and report back to us whether they are doing any good or whether you are just paying out a lot of money to a bunch of coats to do whatever they want to do that may be unconstitutional?

Secretary LEAVITT. We need to hold them to a standard of accountability and performance—

Mr. STARK. When do you plan to start doing that?

Secretary LEAVITT. In the same way we do other programs.

Mr. STARK. You haven't done it yet. If you are going to do it the same way you are doing other programs by ignoring them, as you have faith-based and abstinence training, it sounds to me like you are just giving money to Bechtel, as we have in Iraq.

When do you intend to start supervising this money that you are spending and giving away to these groups?

Secretary LEAVITT. I guess I never thought of Bechtel as faith-based. But Mr. Stark, we do in fact intend and continue to hold them accountable for results in the same way.

Mr. STARK. But you don't. But GAO has said you haven't done that. When do you intend to start?

Secretary LEAVITT. Well, it is a relatively new phenomenon, and we will be judging their effectiveness in the same way we do other programs.

Mr. STARK. When? When?

Secretary LEAVITT. On the same timelines.

Mr. STARK. Which is never, so far. You can't tell me when you are going to start to look after this money that you are spending,

126 million on faith-based and 28 million on abstinence? That may not sound like much to you, but that is over \$150 million a year that you have no idea what it is doing.

Secretary LEAVITT. We have a standard practice with grantees who are faith-based, as well as those that aren't, that we evaluate the effectiveness of their performance—

Mr. STARK. That is not what the GAO said. They said you haven't done anything to evaluate it.

Secretary LEAVITT. Well, our practice is to do so.

Mr. STARK. Well, I hope that your practice—I don't think you are telling us the truth, unless you want to challenge GAO. I will be glad to have you comment on the report. They say you have done nothing. I hope you will certainly start because the taxpayers deserve to see where their money is going.

Secretary LEAVITT. There are times that we do disagree with GAO. But I will tell you that we—and if they are suggesting that we are not holding them accountable, that would be wrong.

Mr. STARK. This was the report when they were still run by Republicans.

Chairman RANGEL. Mr. Camp may inquire.

Mr. CAMP. Thank you, Mr. Chairman. Again, welcome, Mr. Secretary.

I just want to touch briefly on Medicare Advantage a little bit. My understanding, obviously, this is a plan that allows seniors the choice of receiving their Medicare benefits in a private health plan.

These have grown considerably over the last few years, have they not?

Secretary LEAVITT. They have. They present an opportunity for a person to have an integrated care, that is to say, have all of their care provided in the same basic facility in a managed way. People do both enjoy that, and they produce very good results.

Mr. CAMP. Not just integrated, but they have better benefits in these plans, do they not?

Secretary LEAVITT. They do. Because the care is integrated, they receive many benefits that others do not because of the cost savings and because of the value of the integration of their care.

Mr. CAMP. Are these plans not now in more areas than they had been in the past? I understand on average there are 20 Medicare Advantage plans available in each county. Is that accurate?

Secretary LEAVITT. We have now achieved a ubiquitous coverage. In other words, there are plans available in every area of the United States, and I might add that we have seen a robust acceptance of them. We now have more than 7 million people who have opted on their own to make that decision. They have done so for the reasons that you have stated.

Mr. CAMP. That is roughly 18 or 19 percent of all Medicare beneficiaries are now enrolled in Medicare Advantage?

Secretary LEAVITT. Each one having made a decision on their own to do so.

Mr. CAMP. These plans are saving seniors hundreds of dollars a year? The Medicare Advantage enrollees out-of-pocket costs are significantly lower than traditional Medicare enrollees. Is that correct?

Secretary LEAVITT. They are. The benefits that come both in the form of savings, 25 percent of it inures to the Medicare Program and 75 percent would go to the beneficiaries themselves.

Mr. CAMP. So their out-of-pocket costs are more than a third less, from what I understand.

Also, these plans are important to underserved areas. I know many of us on this Committee, such as I, represent underserved areas and minority populations. Tell me about how Medicare advantage works in those areas.

Secretary LEAVITT. Well, our aspiration and now our accomplishment is to have them available in every area. A person is able to select a plan. They are able to make decisions that will in fact guide their health care on their own. They are able to not only receive the capacity to make decisions, but they are also able to receive additional benefits.

Mr. CAMP. These are important to low income beneficiaries. A significant number of the enrollees are low income.

Secretary LEAVITT. A very high percentage of them. A significant percentage of them are from low income areas and from people with low income.

Mr. CAMP. Thank you. I just also wanted to mention the President's proposal with regard to health insurance. I appreciate your testimony that just because you have a job that doesn't have employer-provided coverage, you shouldn't be at a disadvantage compared with someone who does.

What projections do you have on the increase of the number of insured that would come about as a result of the President's proposal?

Secretary LEAVITT. That will depend ultimately on the number of states who undertake the effort of creating an affordable choice in their state. I indicated that there are many states now who are working on such plans, some of which have been made public. Others have not.

But you can take a state like Michigan, for example. Governor Granholm has put forward a proposal that would cover 550,000 uninsured people in the state of Michigan alone with a basic plan. We are working with them to find a financing mechanism. The state of California. The state of Texas. The state of Indiana. You can go all the way down the line, and you will find that there are states all over the country who are now putting forward proposals.

Most of the dilemmas they can solve on their own. Some of them they cannot. The ones that we have brought forward to you today, asking the Congress to assist, are those that they will find value in Federal action.

Mr. CAMP. As you look at this proposal, I think earlier as we had a discussion, the question was raised: What about the unintended consequences of a proposal like this? Would there be people who would find themselves uninsured as they would lose employer coverage.

Are there going to be people caught in the middle who lose that employer benefit but then don't go on to be able to afford coverages? Are there any ideas on that?

Secretary LEAVITT. I find that argument misplaced. The average employer plan is \$11,500 a year. The average exclusion that

will be given—the standard exclusion would be 15,000. In other words, this will benefit 80 percent of those who are in employer plans and, I might add, 100 percent of those who have no coverage, 100 percent.

Now, you combine that with our Affordable Choices initiative, and we will see millions of Americans who have health insurance who currently do not. That is our aspiration, every American having affordable basic insurance at their access.

Mr. CAMP. All right. Thank you, Mr. Secretary. My time is expired.

Chairman RANGEL. Mr. Secretary, how long can you be with us today?

Secretary LEAVITT. I think 12:30 is the timeframe that—

Chairman RANGEL. Well, there are about 30 Members here, and if we push that 12:30 a little bit, that would allow the remaining Members to have at least 3 minutes, those who persevere. If there is no objection, we will do that. I want the new Members to know that this is not the normal procedure, but the Administration has problems and so we have to accommodate them. I am trying to accommodate everybody.

Secretary LEAVITT. Mr. Chairman, if it would be helpful for me to either come back on an informal basis, or I will make some—I will check to see if I can push a little. I want to be accommodating. I want to be here to be responsive to your questions and—

Chairman RANGEL. See whether or not you can push. We do intend to have informal sessions where we can sit around and honestly discuss the differences. I appreciate that kind offer. It is accepted by the Ranking Member and I.

Meanwhile, we will see how far we can go with this suggestion. Mr. Levin is recognized for 3 minutes.

Mr. LEVIN. Thank you.

Mr. Secretary, welcome. Quickly, in your opening remarks you instead of talking about the budget in detail talked about compassion. We respect that. But a crucial test of compassion is the extent of resources and the use of them.

You say in your opening statement advancing medical research. What is being proposed for NIH is less than inflation, is it not?

Secretary LEAVITT. It is.

Mr. LEVIN. I just want to tell you straight out, I don't think compassion is reflected in resources when there is NIH funding less than inflation. It is not defensible to the people of this country.

Then you say bringing affordable health care to all Americans. I think your proposals would add health care for about 3 to 4 million people.

So, let me just talk to you about the standard deduction. I looked at the amount of employer contribution in the construction industry in southeast Michigan. The average—and these are average—is \$7 an hour. If you do that by 40 hours, 52 weeks, let's take a figure of the employer contribution is \$15,000.

You are providing a standard deduction—it is not an exclusion—of 7500, or maybe 15,000 if the total family is covered. That deduction is worth \$4,000, more or less. So, essentially, you are saying

to the construction workers, instead of having 12-, 13-, 14,000 that you don't pay taxes on, you are going to have a deduction of \$4,000.

How do you defend it?

Secretary LEAVITT. I am not following your example. If a construction worker were making—how much did you say he would make?

Mr. LEVIN. Look. The amount of health insurance is about 13-, \$14,000. That is what the employer is paying. A deduction of 7500 or 15,000 is worth, if it is 15,000, \$4,000.

Secretary LEAVITT. The average individual health insurance would be closer to \$6,000. If you had a family—

Mr. LEVIN. No, no, no. The deduction from the income tax is worth 4—to \$5,000, sir.

Secretary LEAVITT. Are we talking about a married person or—

Mr. LEVIN. It doesn't really matter—

Secretary LEAVITT. It matters—

Mr. LEVIN [continuing]. I mean, because the deduction is going to be less than half of what he doesn't pay on the insurance contributions.

Secretary LEAVITT. The issue is that there are many people who work construction who get no deduction and still have to buy insurance on their own. And—

Mr. LEVIN. So, you are going to take from those who are getting this insurance and give it to those who do not bargain for any insurance?

Secretary LEAVITT. I am going to make certain everyone is treated the same.

Mr. LEVIN. Come to Michigan and I am going to set up a meeting with construction workers. Okay? Will you come?

Secretary LEAVITT. I have been to Michigan twice recently, and I am sure I will be back again.

Mr. LEVIN. I will set up a meeting.

Secretary LEAVITT. Well, that would be good.

Mr. LEVIN. I want you to defend your proposal.

Secretary LEAVITT. Well, let me tell you about another proposal I am working on in the state of Michigan with Governor Granholm. Governor Granholm would cover 550,000 people with an affordable basic plan, a lot of whom are construction workers who don't have any insurance right now because they have to buy insurance after they pay their taxes. I hope we can meet some of them, too.

Mr. LEVIN. I am in favor of that. Now, we are pushing you to do that. But I want you to come and talk to construction workers. Okay? I will set the meeting up.

Chairman RANGEL. Mr. Herger.

Mr. HERGER. Thank you, Mr. Chairman.

Secretary Leavitt, you mentioned that the President's budget attempts to slow the growth of Medicare spending with several proposals that will save a total of \$66 billion over the next 5 years. Since 2000, the monthly premiums for Medicare part B have more than doubled. Can you tell me how the President's budget proposals would affect the future growth in beneficiary premiums?

Secretary LEAVITT. Anything we can do that will slow the growth of premiums without affecting directly beneficiaries will in

fact have a beneficial effect on their premiums as well. What drives premiums to beneficiaries up are costs that are out of control.

The sooner we act to begin to find ways in which we can reduce the growth rate, the less their increases will be over time. This is about not only keeping the trust fund sustainable; it is about finding ways to keep the premiums affordable.

Mr. HERGER. So, you are saying you feel by doing this it would pull the costs of premiums down, or they wouldn't rise as rapidly as they are?

Secretary LEAVITT. There is no question that if we are able to suppress the growth rates of Medicare, that beneficiaries' premiums will also be reduced.

Mr. HERGER. So, you are saying that premiums under the budget would be less than they would be if we do not take action to slow the growth of Medicare?

Secretary LEAVITT. In the long term, there is no question that if we allow these costs to go unchecked or un-dealt with, if we do not treat this patient in time, they will become substantially less well and beneficiaries will pay a higher cost.

Mr. HERGER. Do you have an estimate of how much the average senior citizen would save on monthly Medicare premiums as a result of the reforms in the President's budget proposal?

Secretary LEAVITT. I do not have that in front of me, but there is no question that that would be the case. If we allow these costs to continue to grow unabated, it will be harmful not only to the Treasury of the United States but also to the pocketbooks of consumers.

Mr. HERGER. Well, Mr. Secretary, I want to thank you for your proposal. I want to thank you for not only going to Michigan, but also coming to California very frequently, including my northern California rural district. Thank you very much. I am very encouraged by what I hear you saying and the direction that we are attempting to move to get in control these out-of-control health care costs. Thank you very much.

Secretary LEAVITT. Thank you.

Chairman RANGEL. While you are taking these invitations, I don't think you are ready for my hospitals yet. But I will work on that.

Secretary LEAVITT. I promised I would be there, Mr. Rangel.

Chairman RANGEL. The chair recognizes my friend John Lewis from Georgia for 5 minutes—3 minutes.

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

Thank you very much, Mr. Secretary, for being here. I like your words this morning. You said in your opening statement that we are a compassionate nation. You further stated that it is your aspiration, your hopes, your dreams, that everyone would have affordable health care, access to health care.

Do you believe that health care is a right?

Secretary LEAVITT. I believe that, as I suggested, it is certainly a need. It is one of those things that we aspire as a nation for everyone to have access to an affordable basic insurance policy. There are personal responsibilities that are involved in all of our needs.

In a nation as compassionate as ours, when a person is not able to meet that individual responsibility, we find ways to help them. I believe that is the case with health care.

Mr. LEWIS OF GEORGIA. Thank you, Mr. Secretary. Mr. Secretary, I want to talk about the shortfall in the SCHIP program for this year. In Georgia and 16 other states, we will run out of money to cover poor children. I just got word since this hearing that in the state of Georgia, on March 7th they will stop enrolling new participants.

Is there something you can do? Can you and the Administration fix this problem, solve it right now administratively?

Secretary LEAVITT. Unfortunately, Mr. Lewis, we cannot. That will require an act of the Congress. I will be in Georgia on Monday. I was on the phone yesterday with Governor Perdue. We are working to give Governor Perdue and all other Governors in this situation all the tools that we have available.

Ultimately, the Congress will need to act if they are to meet those short-term needs as we move toward reauthorization of the program, which we believe needs to occur this year.

Mr. LEWIS OF GEORGIA. It is my understanding, Mr. Secretary, that in the past, you have been able to fix it. Can you fix it one more time for the children in Georgia and the 16 other states?

Secretary LEAVITT. It is our information that there are five states who are facing difficulties. I do not have administrative authority. I think it is universally understood that the Congress would need to act in order to affect—we have proposed a way it could be done. It could change the law to allow a 2-year cycle of reallocation instead of a three. We would then be able to administratively fix it.

Our objective is to help the states through this. We believe that as we reauthorize the program, we all ought to focus on the ways that we could keep it from happening the next time. In the meantime, we are doing all we can to give states tools. But the Congress will have to act to solve this problem.

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

Chairman RANGEL. The chair recognizes Mr. Camp for questioning as the—he did? Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman. Secretary Leavitt, good to see you again.

As you know quite well, I am sure, according to SAMHSA, between 22 and 26 million Americans are suffering the ravages of chemical addiction, illegal drug addiction and alcoholism. Last year, according to SAMHSA, 150,000 people died as a direct result of this disease. According to a study by Brandeis University, it costs our GDP \$400 billion in lost productivity and absenteeism.

I don't think there is any question in my mind, at least, that chemical addiction is America's number one public health problem. Millions of Americans need but cannot gain access to treatment for their addiction. Last year 300,000 Americans were denied treatment.

Many were discriminated by insurance companies and their health plans. Barriers were erected that made it impossible for them to get treatment vis-a-vis treatment for what are deemed

more physical diseases. Medicaid funding was inadequate, and we all know the situation at our VA hospitals.

This results in a tremendous burden, to say the least, to families, to taxpayers, through increased health care, criminal justice costs, social service costs. The average untreated alcoholic, for example, incurs health care costs twice as high as mine. I happen to be a grateful recovering alcohol of 25½ years, and according to the statistics, the health care costs for someone who goes untreated are twice as high, 100 percent higher than mine.

Now, taking all this into account, I have got to say I am troubled to see that SAMHSA, the Substance Abuse and Mental Health Services Administration, in this budget is cut by \$159 million, from 3.2 to \$3.05 billion. How are we going to tackle, how are we going to address, our Nation's number one public health problem by cutting funding for this critical agency?

Secretary LEAVITT. Congressman, I think what you have suggested is right, that it is a very serious problem. We are working with the states. We are using the finances that are available to us to try to leverage them and to find more ways to do that. There is no question that doing so leverages those dollars.

Mr. RAMSTAD. Do you agree that this is, if not America's number one public health problem, one of the most pressing public health problems, addiction, chemical addiction?

Secretary LEAVITT. There are many that are in that category—obesity, childhood obesity, addictions, all of those. While I was the Governor of Utah, it became very clear to me that a very high percentage of those that we dealt with on our welfare rolls, for example, were there as a result. Our prisons were full of people who had started with a chemical addiction. There is no question that these costs go on and on and on.

Mr. RAMSTAD. In fact, according to Columbia University, 82 percent of all people in prisons and jails are there because of their addiction. We are not dealing with it as a nation, and I am really saddened and disappointed, and more than that, Mr. Secretary, to see this significant cut from SAMHSA.

I hope the Congress will, in its wisdom, restore these cuts. I hope Health and Human Services will be more proactive in dealing with this epidemic of addiction in America. Thank you, Mr. Secretary.

Chairman RANGEL. Mr. Neal is recognized for 3 minutes.

Mr. NEAL. Thank you very much, Mr. Chairman. Thank you, Mr. Secretary.

Mr. Secretary, could we begin with the acknowledgment that was offered yesterday by Rob Portman when he said that Social Security was one of the great achievements of American history?

Secretary LEAVITT. Congressman, there is no question that it provides a social as well as financial foundation. I was in China recently and many other countries, and see how they wrestle with the potential of an aging population. We have challenges. They have even greater challenges. To have what we have is worth protecting, and making certain that we are able to sustain it over a long period of time.

Mr. NEAL. Would you agree with the same premise that I offered about Medicare?

Secretary LEAVITT. There is no question that Medicare is a fundamental part of the way we as a compassionate nation meet the needs of citizens that we all desire. There are ways we can improve both of those programs, but they are very important underpinnings of our society.

Mr. NEAL. Thank you for that acknowledgment, Mr. Secretary.

Let me take you to the more specific case that we addressed a bit earlier this morning, graduate medical education and how important that is, not only as offering first-rate training to arguably the best doctors in the world, but the role that it plays as an economic engine as related to the growth of biotechnology as well.

In Massachusetts, as is the case in New York and California and New Jersey, what graduate medical education has done to promote economic growth is sometimes offered as a separate argument when the two are very much linked. I would urge you, as this budget is being offered, during the discussion of budget priorities to note just how important GME is not only in terms of first-class doctors, first-class health care, first-class employment opportunities, but also the spinoff as it relates to the growth of biotechnology across America. Perhaps you could comment on that.

Secretary LEAVITT. There is no question that we need graduate medical education. There is no question we need to have a means of financing it. I would argue, and our budget proposal clearly prefers, that using Medicaid, for example, or Medicare as the means of financing it is short-sighted, short-sighted because what it means is we have fewer dollars available to us to meet the needs of the poor.

We ought to find a way of financing medical that is overt, not covert. Medicaid, for example, was designed to help those who are disadvantaged because of low income. It was not put there to be the funding source for graduate medical. We ought to come up with a system that causes everyone to contribute, not just our programs for the low income.

Mr. NEAL. Do you have any indication what percentage of Medicaid dollars? I think we have a pretty good idea of the Medicare supplement. But Medicaid dollars, what percentages go to GME?

Secretary LEAVITT. I can get that. I don't have it on my—

Mr. NEAL. All right. Thank you.

Chairman RANGEL. The chair recognizes Mr. Becerra for 3 minutes.

Mr. BECERRA. Thank you, Mr. Chairman.

Mr. Secretary, thank you very much for being here. As I said, I look forward to working with you, as I know my colleagues do, on some of these proposals.

Actually, I want to sort of feed on what Mr. Neal was saying. The indirect medical education payments, it seems to me that in your proposals, the budget proposals you have that propose to eliminate IME payments to teaching hospitals, it appears that you are arguing that the teaching hospitals are already receiving these types of payments through the Medicare Advantage plans through a pass-through; that they will go ahead—these Medicare Advantage plans are paying teaching hospitals for some of the costs of teaching the next generation of health care providers, doctors, nurses, and so forth.

But I am not sure if the evidence is out there that this is occurring. So, if we were to move forward with the proposal that the Administration has provided us to eliminate IME funding, indirect medical education payment funding, you are going to have a massive impact on a lot of these teaching hospitals that rely on those payments to help them sustain the work that they do in teaching the next generation of providers, of doctors and so forth, and also helps them sustain the level of care that they provide to many, many people throughout the country.

I am wondering if you could tell me that you will provide us with the evidence that led you to make the cuts to IME, to these teaching hospitals, so we can know on what basis you are deciding to de-fund some of these teaching hospitals of moneys, resources they need to be able to provide not just health care but the teaching necessary to teach the next generation of health care providers.

Secretary LEAVITT. You are right, we do believe that many of these expenses, including bad debt, are built into their rates. But it goes beyond that with graduate medical education. I dealt with this as Governor. There needs—

Mr. BECERRA. Because I am going to run out of time, if I could just know, will you provide us the evidence that led you to this particular position on doing the cut on IME?

Secretary LEAVITT. We will provide you with the information we have. But I do just want to make the point, Congressman—

Mr. BECERRA. Certainly.

Secretary LEAVITT [continuing]. That there is a need for us to rethink the way we do graduate medical—everyone in the rate system needs to be bearing some part of that cost because everyone gets the benefit. We are right now using Medicaid rates and Medicare rates as the means of doing it.

If we are going to do it with Federal contributions, fine. But let's come up with a line item that says this is how we are going to do it. Right now we are leaving the vast majority of the entire system out of it. They should be paying their part.

Mr. BECERRA. I think you will find a lot of support in reexamining how we do the payments because we need to have a solid base of funding for these institutions, these facilities that have committed to provide the next generation of health care providers to teach them, at their own cost. Because you can't go out there and attract as many people to your institution if you tell them that they are going to have a lot of students doing some of the work, that the residents are doing the work. Everyone wants that 20-year veteran to do the operation.

So, I agree with you there and hope we can work on that. So, I thank you for your response and look forward to receiving the information.

Thank you, Mr. Chairman.

Chairman RANGEL. The chair would like to recognize Mr. English for 3 minutes.

Mr. ENGLISH. Thank you, Mr. Chairman.

You know, Mr. Chairman, I was listening to the gentleman from Michigan defining compassion maybe the way we sometimes all too often do, simply based on outlays. In my view, the true test of com-

passion is how effectively resources are used, and really it is only measured in results.

Nevertheless, and I know the Secretary knows my district very well, we have people in my district in our hospital community who are achieving a great deal with a little, and are very dependent on the resource decisions that we make here in Washington.

On that point, Mr. Secretary, the President's budget reduces payments to hospitals effectively by setting the annual update to the market basket minus.65 percent. Never mind that we are debating about an adjustment of an increase. This is very significant because last month, MedPAC recommended to Congress that it give hospitals a full market basket inflationary update for Fiscal Year 2008.

Nearly two-thirds of America's hospitals lost money treating Medicare patients in 2005. MedPAC has estimated that overall hospital Medicare margins will drop to negative 5.4 percent in 2007, and Medicaid hospital margins are even lower.

I know the Secretary is intimately familiar with these facts. My question to you, Mr. Secretary, is: Do you believe that the President's proposal is adequate funding to allow hospitals in places like Erie, Pennsylvania and Sharon, Pennsylvania to meet the real challenges of new and costly pharmaceuticals, new technologies, labor shortages, preparation for pandemics, and simply making sure that the people who walk into the emergency room are taken care of?

Secretary LEAVITT. Congressman, in the development of budget, we have to make certain assumptions and we have to make decisions. You know this. I looked at the hospitals as well as my colleagues and concluded margins in hospitals are strong right now. MedPAC themselves say it is about 13 percent.

I see access to capital being strong. I see access to care being strong. So, I had to come up with a conclusion on how we would arrive at a figure. MedPAC is a recommendation. Congress in the past has met it, and other times they haven't. In fact, most times they haven't.

I looked at the productivity figure that they provided, which was 1.3 percent, and said, if we are having a productivity increase of 1.3 percent, let's just split that. Let's have half go to the Federal Government and half go to—or to the beneficiaries, and half go to—or the taxpayers, and half go to the beneficiaries. That is how I arrived at the.65 percent. That is, frankly, a better split than many Congresses have done in the past regarding MedPAC.

Mr. ENGLISH. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Chairman RANGEL. The chair recognizes Mr. Doggett for 3 minutes.

Mr. DOGGETT. Thank you, Mr. Chairman. Thank you, Mr. Secretary.

You surely share my view that tobacco is the deadliest legal product marketed today, killing over 400,000 Americans and millions worldwide. Can you assure me that during this month, you will be able to supply a complete response concerning the documents I have discussed with your staff that Chairman Waxman and I have requested to assure us that neither your department

nor any other part of the Federal Government is promoting tobacco overseas?

Secretary LEAVITT. I am informed this morning by my staff of those documents, and I am assured that they are doing the research necessary to give you those assurances. I have to tell you I would be stunned if we found any place, and I would not only stunned, I would be alarmed, and we would move rapidly—

Mr. DOGGETT. I am glad to hear that. I hope you are being consulted because, sadly, I think there have been problems. I hope at the same time you supply the documents this month that you can tell us of anything that your department is doing to encourage the ratification of the Framework Convention on Tobacco Control by the Senate, which has been pending, as you know, since May of 2004. Can you do that?

Secretary LEAVITT. I can give you an update. I am not—

Mr. DOGGETT. Thank you. I will just ask you to submit that with the documents because I want to move to your testimony this morning.

When did you and President Bush first decide that it would be necessary to raise taxes in order to address the problems of the uninsured in America?

Secretary LEAVITT. The uninsured what?

Mr. DOGGETT. When did you and President Bush first decide that you would have to have a tax increase, as you proposed this morning, to address the problems of the uninsured in America?

Secretary LEAVITT. Well, there is no tax increase. There are—

Mr. DOGGETT. Well, if I am a construction worker, as Mr. Levin talked about, or any person who receives a certain level of comprehensive health insurance, as you have testified this morning, as Secretary Paulson told me yesterday, you are planning to raise taxes on it.

Secretary LEAVITT. There are no additional tax dollars raised by this proposal. Eighty percent of those who receive—

Mr. DOGGETT. Well, your own budget proposal says—

Secretary LEAVITT. Eighty percent of those who receive—

Mr. DOGGETT. I understand that you think you help 80 percent. But 20 percent of the people, under your analysis, 30 to 38 million under the analysis of one independent consulting group, will have to pay the new Bush health insurance tax, the first major tax increase this Administration has proposed which, oddly enough, will fall on people who have committed the sin of having a comprehensive health insurance policy.

You don't deny that you raise revenues, which most people call taxes, in this budget, do you?

Secretary LEAVITT. I do. There is no—

Mr. DOGGETT. You don't raise any taxes, as your budget document itself shows?

Secretary LEAVITT. There are no new taxes raised by the—

Mr. DOGGETT. You claim it is revenue-neutral. But the only way it can be revenue-neutral, when you add benefits to someone, is if you raise the revenue with someone else. Your proposal raises taxes on people who have comprehensive health insurance, Mr. Secretary. Surely you will acknowledge and admit that.

Secretary LEAVITT. There is no provision acted on by this Committee or the Congress that makes a change to the Tax Code that does not affect some positively and some less positively or negatively. This proposal does not raise additional taxes.

Mr. DOGGETT. That is a long way of saying, when you refer to negatively, as Secretary Paulson admitted yesterday, that you are raising taxes with this Bush health insurance proposal, this Bush health insurance tax, on millions of Americans. It is the first major tax increase this President has proposed. I agree we need more revenue, but I think this is the wrong target for your tax increase.

Secretary LEAVITT. There is—

Chairman RANGEL. You may complete.

Secretary LEAVITT. Well, there is no—it is indefensible that this country provides a tax benefit to those who receive insurance through their employment and does not provide the same benefit to those who do not.

This does not provide any additional taxes to the U.S. government. It benefits 80 percent of those who are currently in the system, and 100 percent of those who have no insurance.

Mr. DOGGETT. That is why you are raising taxes on the other 20 percent.

Secretary LEAVITT. We will just have to disagree on that, Mr. Doggett.

Chairman RANGEL. The chair recognizes Mr. Pomeroy for 3 minutes.

Mr. POMEROY. Thank you, Mr. Chairman.

Mr. Secretary, what is the Administration's plan on the sustainable growth rate issue relative to physician reimbursements?

Secretary LEAVITT. We look forward to working with the Congress to solve that very thorny problem that we seem to solve for 6 months at a time. We would like to solve it longer range.

Mr. POMEROY. Is there a provision in the budget to solve it longer than the 6 month period at a time?

Secretary LEAVITT. That is a conclusion that we believe we should reach collaboratively with the Congress.

Mr. POMEROY. In other words, no.

Secretary LEAVITT. We have not put forward a proposal, nor have we heard one from the Congress yet.

Mr. POMEROY. Thank you. Your comments there remind me an awful lot of what the Secretary of the Treasury said, looking forward to working with us on fixing the AMT permanently, except there is no money in the budget to fix the AMT permanently. You want to work with us to fix the sustainable growth rate reimbursement issue on physician payments, except you put nothing in the budget to do it.

I think it goes to show, really, a false dimension to this budget, a phony budget. I think some of the frustration, Mr. Secretary, you are finding from the majority side of the panel here is we really had been a little hopeful about more opportunity to work jointly in this budget. It looks to me somewhat like the same old stuff.

Let me move to rural health care because you have indicated that the margins are strong with hospitals and that capital markets respond well to hospitals. In the nonprofit hospitals that I rep-

resent, especially those struggling to keep their doors open in these rural reaches, are not in that situation at all.

There is one reckoning that they are taking about a \$35 million cut in the next 5 years alone under your proposal. These are for institutions right on the edge, just to take rural health care, which is extremely difficult to deliver in a rural setting.

As I understand what you call—although you are not phrasing it as cuts, you go into the market basket, you reduce the adjustment that they are receiving to below what they are finding in terms of their costs, and actually freeze the market basket on home health care. These, without question, impact significantly the income received by these outfits that aren't making any money today.

Do you have concern? How are you as Secretary going to deal with the plight of these rural institutions that are right at the waterline now, going under the budget proposals?

Secretary LEAVITT. Mr. Pomeroy, I will confess to you that I think the way we reimburse health care generally could use a lot of tuneup. It is a witches' brew that very few people understand, and I think it does not allow for us to use the sensitivities that could be and should be used in creating formulas that can be more sensitive to those hospitals like you have described.

I would tell you, on the point you made on the doctor reimbursement issues, I have strong feelings about how we should go about that. I mean, it is very clear to me that some portion of what we reimburse physicians with in the future ought to be based not just on the quantity but also on the basis of our ability to measure value.

I believe that is one of the areas where there is a large land of agreement that could be worked on between the Administration and this Congress. I believe every patient deserves to have some kind of independent assessment of the quality they get, not just in doctors but also hospitals.

I think every patient ought to be able to find out how much it costs, and we ought to be transparent about that. Part of that, part of finding the solution that you are referring to, is making our system more transparent where people can really understand it and make judgments based on value.

Mr. POMEROY. Thank you. My time has expired. The prior secretaries have afforded the opportunity of the CMS director to visit North Dakota to look directly at our situation, meet with the providers. I will be advancing a request to the CMS director, but I alert you to it. I would hope that we can continue that under your leadership of HHS.

Secretary LEAVITT. Thank you.

Chairman RANGEL. The chair recognizes Mr. Hulshof for 3 minutes.

Mr. HULSHOF. Thank you, Mr. Chairman.

Mr. Secretary, welcome. The distinguished gentleman from California, the health Subcommittee Chairman, challenged you on Medicare Advantage, challenged about savings on the integrated care. I think Mr. Camp, to underscore the point he made, is that these Medicare Advantage plans are available to seniors in many underserved areas.

The fact that these plans save seniors, I think, an average of about \$82 a month in reduced out-of-pocket experiences, I know the Chairman of the health Subcommittee has talked about trying to cut those payments.

I guess if I were to engage in rhetorical grandstanding such as I have heard this week in this Committee, I would say how unkind and how uncaring, what an utter lack of compassion, to rob seniors of their current health care choices, forcing 7 million seniors to reach deeper into their pockets, and exacerbating the headlong rush toward insolvency.

But I won't go there. Instead, I do want to talk about something that Mr. Thompson and I have worked on, my good friend from California. Your budget—I want to applaud the fact that your budget embraces the goals of health information technology. I believe that there are—we haven't even begun to see the efficiencies yet of implementing health IT.

One specific area that Mr. Thompson and I have worked on is in the area of telemedicine. Now, I am a bit biased because I think the University of Missouri is the national leader in telemedicine. But I would like to hear your view, Mr. Secretary, the expansion of origination sites, consulting sites that could be reimbursed by Medicare, things like remote monitoring conditions of cardiac arrhythmia, diabetes, consulting with the best medical minds in the country, all via technology.

I personally believe we need to adjust fee schedules so that physicians and others have the proper incentives. Again I think we can save money. It is difficult to quantify sometimes savings from wellness and implementation of technologies. Just in the few seconds remaining, what is your view, especially as enacting legislation or reauthorizing telemedicine reimbursement on this issue?

Secretary LEAVITT. Congressman, I will up the ante a little on you and say we talk about our health care system. I don't think we have a system. I have a credit card in my pocket. I got it from a bank. It is a different color than the one you have. Our banks competed to get our business, but they all use the same system to optimize the value they provide us.

We don't have that kind of system in health care. Our system of health care needs to be built around connectedness. It needs to have quality measures. We need to be able to know the price and compare it to the quality. We need to be able to use those in creating incentives so that we know every person who touches our health has a reason to seek higher quality at lower cost. The key to that is a connected system of health information technology.

Mr. HULSHOF. Thank you.

Chairman RANGEL. The chair recognizes Ms. Tubbs Jones for 3 minutes.

Ms. TUBBS JONES. Thank you, Mr. Chairman.

Good morning, Mr. Secretary. In the anteroom, we were having a discussion about the whole piece of the President's health care proposal. I have heard claims that the President's health proposal will require high income people to pay a larger share of the cost for their health insurance.

But it is not really—that is not what happens. It is really that the proposal actually taxes higher cost health plans, not higher income people. Can you respond to that for me, please?

Secretary LEAVITT. We believe it is just indefensible that we have a tax system that provides a tax benefit to those who get health insurance through an employer, but leaves out people who are uninsured and can't get it through an employer. We would like to level the playingfield. We would like to treat people the same. We think it solves a problem that has actually lingered for a long time.

No Congress ever voted to have this system. This is a figment of the forties with wage and price controls. This system just evolved.

Ms. TUBBS JONES. Mr. Secretary, I love your response. But I only have but 3 minutes, so don't give me a long answer. Give me a reduced answer. Go ahead, please, sir.

Secretary LEAVITT. I think that is about as reduced as I can get.

Ms. TUBBS JONES. Isn't it a fact that the health insurance premiums are based on the risk associated with the people covered by the policy, such that workers in West Virginia would likely pay more than an executive on Wall Street for the health care coverage? Wouldn't your proposal to cap the tax benefit for medical expenses harm middle income workers in hazardous industries?

Secretary LEAVITT. Our proposal would take the radical step of treating everybody the same.

Ms. TUBBS JONES. Except in the United States of America, everybody is not treated the same. We have workers who don't receive any kind of health care coverage. Then we have workers who receive coverage that is paid by their employer. We have workers who can afford to pay into a health savings account, and we have workers who can't afford to do that because their income doesn't allow them to do that.

So, why would you treat them all the same?

Secretary LEAVITT. Well, I guess that is the question. Why would we discriminate against people who, first of all, don't have an employer to help them and are in low income? That is what we are doing.

We are essentially saying to people who currently have employment and currently have insurance and currently get it paid by their employer, we are going to give them an advantage. Then we are going to discriminate against people who don't have a job, who don't have insurance, and don't get any advantage.

This is a very progressive policy to say, let's just level the playingfield and treat everybody the same.

Ms. TUBBS JONES. It sounds really good.

Secretary LEAVITT. It is really good.

Ms. TUBBS JONES. But you understand—no. But you understand under the law, for example, in the discrimination, a policy that appears on its face to be neutral can have a disparate impact in its implementation.

I would suggest to you that the health care proposal that you have put on the table may appear neutral on its face, but when it is applied to workers across the board, it has a disparate impact.

I would ask that you go back and take a look at it and help the American people without any health care coverage.

Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Secretary, if the President's tax cuts which expire in 2010 are not renewed, would you consider that a tax increase?

Secretary LEAVITT. If the President's tax cuts are not renewed, would I consider it a tax increase? Well, there is certainly no question about the fact that the Federal Government would receive more revenue, which would be different than the proposal that we are making.

Chairman RANGEL. Well, that is a good answer to a question I didn't ask.

Secretary LEAVITT. Sometimes that is a good thing to do.

Chairman RANGEL. Very good.

Mr. Thompson is recognized for 3 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. Secretary, Mr. Hulshof touched on an item that is very near and dear to both of us. As he mentioned, we have been working on this for a long time.

But the fact of the matter is since this Administration has been in office, telehealth has been cut by 81 percent. This year it is flat funded carrying that through. This runs counter to even reports coming out of your department in 2001 that stated that telemedicine had a great potential to increase access to health care and to reduce overall health care costs.

I have seen this firsthand. They are good programs, and they deliver savings and good health care. So, I would like to get a commitment that you will work with myself and Mr. Hulshof so we can continue to make improvements in this area.

Secretary LEAVITT. I am a big fan of telemedicine.

Mr. THOMPSON. Is that a commitment?

Secretary LEAVITT. Yes. That is a commitment.

Mr. THOMPSON. Thanks so much.

The other thing I wanted to talk to you about is yesterday Mr. Portman said that some of these hospital cuts, a tremendous amount of hospital cuts in this budget, would be offset by increased productivity.

I represent hospitals and I represent areas. I have one county in my district that has lost two surgeons and ten primary care doctors in 2005 alone. The county is short on professionals. I would submit to you that there is no way that you can make this up in increased productivity.

I am just glad my wife, the nurse, wasn't here when Mr. Portman said that yesterday, or any other nurse across the country, for that matter. It can't be done. I think these cuts are going to exacerbate already tough conditions. These tough conditions are really seen in rural communities. I want to go on record as saying that.

In regard to the rural issue, in your prepared testimony you only use the word rural once, one time in the whole testimony. That was when you said that a cadre—you are talking about \$2 million you have requested to bring a cadre of health care workers to the rural areas of Central America.

At the same time, the budget zeroes out funding entirely for a host of rural programs in the United States, programs such as rural health flexibility grants, rural health network and outreach grants. This is going to be devastating to rural parts of the country, which are often underserved areas.

I would like to know what you propose to do about that. It is not that I don't want to help Central America, but I think we have enough folks right here that need to be helped in rural areas and we need to focus on them.

Secretary LEAVITT. Mr. Thompson, I would just remind you that I was Governor of a state where there are parts so rural you had to order a haircut through the catalogue. We had to deliver health care to them. I am a big—I understand this problem and I commit to work with you on this because—

Mr. THOMPSON. Well, I appreciate that. I would just like to see more admitting of that problem in the document that lays out the priorities of our government and our country. We need to really double down our effort in this regard.

Mr. THOMPSON. Our country did a good thing when we put into place the Medicare Modernization Act, which in essence doubled the \$25 billion into rural health care. We need to figure out ways to use those resources in combination on things such as rural telemedicine. So, this is a subject we will work on.

Chairman RANGEL. The chair recognizes Mr. Brady of Texas for 3 minutes.

Mr. BRADY. Thank you, Mr. Chairman.

I agree with our Democratic colleagues on reimbursements for physicians and other providers. It is a terrific problem that we need to address. I do disagree that it is up to you to find the solution. Since the cost and the complexity of finding the right reimbursements and the way to pay for them is really going to be a very difficult solution, I really think it is our responsibility in Congress to find that.

I also admit I am not a big fan of the Medicare negotiation bill that passed the House recently. I see it more as a gimmick than a serious way to really help lower drug prices. I am hopeful that we can work together across the aisle on issues like making sure seniors can see doctors they know and who know them, make sure they can get cancer treatment in the most convenient settings for them, that they can get the MRIs and medical equipment in ways that are both cost-efficient for us as a government but effective for them as a patient.

Let me ask you a specific question related to the issue of access to the lifesaving biological therapy known as IVIG. I know you are familiar with it. I am concerned Texas patients are suffering or even dying because they may not have the best access to this drug.

I know you have heard from a number of Members, including me. I appreciate your willingness to work with us. The questions are: Do you know when we can expect completion of the Assistant Secretary for Planning and Evaluation's study on IVIG? Is the Administration planning any revisions in Medicare reimbursement policy for part B physician-administered drugs like IVIG either in this budget or in future rulemaking?

Secretary LEAVITT. Mr. Brady, a specific answer to your question will require that I consult with others. It might be better for me to respond in writing, which I will—

Mr. BRADY. That would be great. Or if I could call because the study—I think we are all anxious to see when that study will be done. Maybe I will follow up with one of your folks on the phone, and then go from there, if you don't mind.

Secretary LEAVITT. Thank you.

Mr. BRADY. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you. Mr. Blumenauer, are you prepared to inquire? Mr. Kind? Mr. Pascrell for 3 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Secretary, I want to go to the heart of what is happening in New Jersey and then connect the dots back to what you are proposing. We have a report that is out of New Jersey that is not very positive. Federal guidelines say a family of four living on about 19,000 a year is poor, a salary that is not possible for anyone, especially in a state as expensive as New Jersey.

In setting the qualifications for program participation, such as in Medicaid, based on national averages, how do you account for places, especially urban areas, with a much higher actual cost of living? The budget will limit SCHIP to children at or below 200 percent of poverty. Because of the high cost of living in New Jersey and many other states, the state currently serves children and their parents up to 350 percent of poverty.

With this new rule that you have in this piece of legislation, thousands of New Jersey children are going to be dropped from that particular program. This is cruel and unusual punishment. The numbers are very clear. In the past 3 years in the state of New Jersey, children without health insurance have climbed appreciably. Between 2001 and 2005, it went up 9 percent, and 2006 is another 17,000 more children who are uninsured. You are going in the wrong direction, Mr. Secretary. This doesn't even come close to covering the children that are needed, and I am only giving you one example in only one state.

So, in order to qualify for Medicaid or nursing facilities or other long-term services, whether we are talking about kids or whether we are talking about older folks like myself, the allowable home equity amount is \$500,000. States now have the option of increasing that limit to \$750,000. New Jersey does this in part because of the high cost of housing. The President's budget seeks legislation that would cap the allowable home equity amount to 500,000 in all states. You are going to be hurting senior citizens.

In a time when we should be working for more health insurance coverage, you are driving more folks out of coverage. What sort of mechanisms are in place that are going to take care of these people? I am giving you very specific examples in a very specific state on very specific parts of the population, children and seniors. What is your response?

Secretary LEAVITT. Mr. Pascrell, I have some specific answers. First of all, with respect to children, our proposal would—our policy in pursuing the reauthorization would leave all children who are currently covered under SCHIP as covered. We would go beyond

that. We believe we ought to be providing every American access to an affordable basic policy. I have known that—

Mr. PASCARELL. Well, you are changing the threshold, Mr. Secretary. You are saying that the state cannot go to 350 percent.

Secretary LEAVITT. Going forward. But those who are covered would be covered.

Mr. PASCARELL. You are still cutting out a lot of kids.

Secretary LEAVITT. We believe we have got to use other mechanisms. I am currently working with Governor Corzine—I met with him last week; I will meet with him again, I think, on Tuesday—on his proposal to expand access to affordable basic coverage to every citizen of New Jersey, including all of the children, I might add. SCHIP needs to be a very important part of that.

Mr. PASCARELL. Mr. Secretary, this is not only going on in the state of New Jersey. The rule applies to the entire nation, as you well know.

Secretary LEAVITT. We are working with—

Mr. PASCARELL. This is unacceptable. It is cruel and unusual punishment. We are talking about kids and seniors, least able to protect themselves. Least able.

Secretary LEAVITT. May I respond, Mr. Rangel?

Chairman RANGEL. Yes.

Secretary LEAVITT. You think it is cruel and unusual policy for us to attempt to create an affordable basic policy for every American?

Mr. PASCARELL. If that is what you were doing, I would agree with you. That is not what you are doing.

Secretary LEAVITT. It is exactly what—

Mr. PASCARELL. This is a shell game. You know it and I know it.

Chairman RANGEL. Ms. Berkley is recognized for 3 minutes.

Ms. BERKLEY. Thank you, Mr. Chairman. Thank you very much, Secretary Leavitt, for being here. The last time I saw you, we were on a panel in Las Vegas regarding the bird flu pandemic or potential of one.

I was pleased to see that the budget contained information technology priorities. My husband's own practice just went to a paperless practice, and the costs of doing that are extraordinary. The costs of training older doctors is even more extraordinary because they are not used to that. So, I like the emphasis.

But I want to talk to you about two issues that I think are very important, and that is my seniors and the children in my congressional district. I am sure you know my district very well, having been there. You know it is the fastest-growing area in the country. While our rapid growth has certainly led to a booming economy, it has given us a number of challenges.

Because Federal funding is often dependent on population, since our growth is so extraordinary, we often lag far behind. So, the resources that are available, it hits—if there is a cut, or even if you keep funding level, where it was the year before, it hits my district in a disproportionately negative way.

Now, there are two issues that I want to talk to you about. One is Medicare reimbursement, and I will be very happy to hear about your feelings that you discussed regarding quality of care and

Medicare reimbursement. But I have a number of doctors that are contacting me quite often, telling me they can no longer afford to care for Medicare patients because they are not getting the reimbursement. If you lose money on each patient, believe me, you don't make it up in volume.

So, when you talk about not addressing the Medicare reimbursement crisis in this country, you are going to be having a number of doctors who simply are not going to continue to provide services, medical services, for a growing senior population, particularly in my community. So, I see a looming crisis for my seniors not being able to get the medical attention that they deserve and that they need.

Also, when it comes to SCHIP, 31 percent of the children in my state are uninsured. When you talk about SCHIP even staying level, knowing the number of children that I am getting into my congressional district, this is going to be a killer for them because OMB just said there are 400,000 children that will not be covered.

What are we going to do about my kids when the SCHIP gets cut? What are we going to do about our seniors if we don't properly reimburse our doctors? How do we get a budget here in Congress that is—I won't call it fraudulent but it might as well be because it doesn't accurately reflect the costs of these programs.

Secretary LEAVITT. First, let me just quickly say that physicians need to be reimbursed in a way that will cause them to continue to serve Medicare beneficiaries. If they aren't, I have got a big problem because I am in charge of 43 million of them.

Second, on CHIP, I was here when we negotiated the last formula, and they are hard. My advice to you would be to make certain that growth states are treated well in that formula.

Ms. BERKLEY. Thank you for your advice. But the reality is the budget that you are testifying for today does not take into account the needs of our seniors and needs of our children.

Chairman RANGEL. Mr. Kind is recognized for 3 minutes.

Mr. KIND. Thank you, Mr. Chairman. Mr. Secretary, thank you for being here and being so gracious with your time in the pre-hearing meeting that we had.

I just want to reiterate, for a parochial concern in Wisconsin is the expiration of the Senior Care program later this summer. We look forward to working and talking with you, see what we can do to extend that program, which has proven very, very popular with our seniors in the state.

I think it has been well crafted. It has had wide bipartisan support. I know the Administration has concerns about funding for Part D now in light of some of the state programs. But hopefully we can think creatively and imaginatively in how we can create a win/win situation.

Another issue that Governor Doyle in Wisconsin is trying to move forward on as quickly as possible is major investment in health information technology and what we can do to ramp that up. The interoperable system, I think, is something we have got to strive for and create the right incentives.

But right now there is no mandate. I would like to hear your viewpoint in regards to what we can do to further encourage the spread of health IT throughout the country so we have a better

billing system that will be cost-effective, so we enhance quality care, have a better tracking system. I think it is obviously something whose time has come, and I think there are greater incentives we can be providing at the Federal level to see that that is done.

Secretary LEAVITT. Very quickly, the first thing is adopt standards that everyone has the confidence, if they buy a system, they know it will be interoperable. That is number one.

Number two, we need to drive adoption among providers in a number of ways. One is to make certain that as we contemplate fixes on reimbursement rates, that we are contemplating the need for their technology.

But also, payors need to become clear that we are intending to make this a prerequisite. The Federal Government has now pledged that in the future, if you are doing business with us electronically, we expect you to do it on a system that is using standards that are compatible.

We are making substantial progress in all of those areas. In the limit of time, I will look forward to an opportunity to talk with you in more specifics.

Mr. KIND. Great. Thank you, Mr. Secretary. Thank you, Mr. Chairman. Yield back.

Chairman RANGEL. Mr. Blumenauer is recognized for 3 minutes.

Mr. BLUMENAUER. Thank you, Mr. Secretary. I appreciate your joining with us in this exercise today. I think in its own way it is worthwhile. I appreciate what you have done in the past. An area that I have been interested in has been livability and environment, and Envision Utah, in another career that you had, I thought was a very interesting exercise.

I am hopeful that you will bring the same sort of creativity and interest and flexibility in the 30,000-foot view into this discussion today. I personally am intrigued with the opening that is presented in a couple of areas that you have characterized as seeking equity in coverage, the deduction potential limitation and shift to deal with it more broadly. of means testing—we have got resource issues, and ultimately these are going to be types of the solutions in the long run.

There are consequences that some of my colleagues have mentioned, and I hope that we are able to sort of dive in and think through about how to move them forward. But I think that is a beginning.

I hope it is done in the context of a broader resource question that we are going to have in other areas that are the responsibility of this Committee, and I hope it sets up a principle that we can explore further in other aspects of tax and revenue.

I would just like to offer up one little area for your consideration in terms of getting the most out of resources and areas under your purview. I have been mystified in the past as I hear from people in the health care industry about some of the audit function, some of the people getting back in and dealing with compliance, where huge resources are devoted to relatively modest problems rather than focusing our resources on compliance on people who are the outliers.

In almost every community, we can identify people who are, frankly, probably abusing the Medicare and Medicaid program, but having hospitals and experienced practitioners jump through hoops.

Is there a way that we can work with you and the smart people who work with you to focus this compliance on the 2 or 5 or 10 percent of the people who are truly questionable to stop abusive practices, to recover money, and to not abuse the vast majority of folks who are just sort of rolling ahead and doing their job? Maybe spot-check them, but focus where the problems really are. Is there a potential for us to do something like that?

Secretary LEAVITT. That would be a mutual interest. This is not an easy proposition. We have contracted and continue to contract with people who can help us look at the streams of bills and claims that come in to Medicare and Medicaid to identify the trends not just as a matter of being able to prioritize but also to help us focus on the group that you have talked about.

There are areas where we know that we need more resources. I was in Miami not long ago, and I went out to see a series of durable medical equipment dealers. It was the most disheartening experience of my career politically. I saw doorway after doorway after doorway where obvious fraudulent activity was taking place, where millions of dollars was being billed in a short period of time. I saw office buildings full of these places.

I came back resolved that we were going to focus on those. We need more resources to do that.

Mr. BLUMENAUER. Well, this is a special area I would love to—

Chairman RANGEL. I would like to recognize Mr. Porter for 3 minutes.

Mr. PORTER. Thank you, Mr. Chairman. Thank you, Mr. Secretary. Appreciate the opportunity to meet this morning in a bipartisan manner with Members of the Committee. To you and your family in Nevada, we appreciate it.

We had a chance to speak this morning about a challenge we are having in Nevada that is parochial but very important. We have found serious challenges with our child welfare system because of the plan that you put into place to check the different programs across the country. I appreciate that HHS is going to be investigating that problem at home.

Could you explain for me a little bit about the child welfare program option that is something for states? Do you know or do you have that available now? Could you help explain that to me?

Secretary LEAVITT. I am not sure exactly what you are referencing. I can give you an overview how it works.

Mr. PORTER. If you would, please.

Secretary LEAVITT. That would be—the child welfare is essentially a state function. Our role as the Federal Government is to both set standards and then to provide some resources.

While I was Governor, frankly, this is an area that I wrestled with the entire 11 years I was Governor. Within 2 weeks of the time I was elected, we became the subject of a lawsuit because of, frankly, things that needed to be fixed. Through that entire period of time, we wrestled with this.

One of the problems we had is that there were no standards federally that we could say, here are the things that have to be done to be considered a good program, and here's how we stack up. That has now been changed. There is a series of criteria that we are using to judge child welfare systems against so that they have a measure of their own quality.

Those are the two major things. Now, some states have chosen to delegate that to a county level, and I think that has been the case—

Mr. PORTER. Exactly.

Secretary LEAVITT [continuing]. in Nevada. We work with the state, who then has a responsibility to oversee each of the counties. But our primary goal is standard-setting and resource development.

Mr. PORTER. Mr. Secretary, I again want to thank you. Because of the guidelines you have put in place, we have found serious deficiencies in the Clark County system where children have been put at risk. So, I want to say thank you very much and appreciate your additional help.

Secretary LEAVITT. Thank you.

Chairman RANGEL. The chair recognizes Mr. Crowley for 3 minutes.

Mr. CROWLEY. Thank you, Mr. Chairman. So, much to ask and so little time to do so, Mr. Secretary.

I just want to follow up very quickly on the Chairman's question to you before, and you attempted to answer before he asked the question. If someone has a tax benefit derived from an employee-sponsored health plan and that tax benefit is reduced or eliminated, do you believe that is a tax increase to that individual?

Secretary LEAVITT. A tax increase is something that raises more revenue for the Treasury of the United States.

Mr. CROWLEY. So, what I really think here is there is a lot of doublespeak that is going on. I think it is all a matter of size. If it is a big tax cut in the Bush tax cut plan, then yes, it is a tax increase. But if it is a smaller tax issue, then it is not a tax increase.

But Mr. Leavitt, just to move on, the recent release of the President's budget has again zeroed out the Health Professions Account in the Title 7. In fact, in the HHS budget, you give this program a narrative rating of ineffective.

I have been a long supporter of the Health Professions Account, as I believe it will address the impending shortage of doctors in our country. Some expect upward of a 30 percent need in the future. It creates a pool of new doctors, and allows students from under-represented racial and ethnic groups into a career of health beyond doctors, nursing and other fields.

In essence, Title 7 and similar programs under it, including the Centers for Excellence and Health Careers and Opportunities programs, help address the serious and growing issues of minority health disparities in our country. I represent parts of the South Bronx where there is a tremendous need. Albert Einstein Medical School is one of the schools that participated in that program that will be cut now.

Can you please explain to me why your agency voted these health professional programs ineffective, and also explain to me, if they are ineffective, what other programs are included in the President's budget to address the growing issue of minority health disparities?

Secretary LEAVITT. Mr. Crowley, any budget is a constant balancing against noble purposes. We had a conversation earlier about the times we agree with GAO and the times we disagree. This was a time we agreed with them. They viewed this as an under-performing program. We concluded that we ought to put more money into basic nursing and basic health professions.

While I am on that subject, may I just say I am of the belief that if we are going to meet the needs of nursing and other allied health professions, we have to adopt a different model. If we are constrained by the bricks and mortar process that we have right now, even if we are running at full tilt we can't get where we need to go.

I am hopeful that we could work to find ways to not only meet the needs of advanced nursing, but to expand by using the kind of hospital-based programs that you have spoken of.

Mr. CROWLEY. Mr. Secretary, I have seen this program in my district. I have seen it work. I have seen it deliver health care to thousands of people in the Bronx and in the city of New York. So, I would hope that you will take another look at this.

Finally, I am writing a letter to you and to HRSA Administrator Duke regarding extending the HCOP and COE programs designation so these hospitals and teaching schools can apply for NIH grants. This allows them to continue to apply -not asking for additional funding from you, but allows them to apply for grants.

This will not burden the government any more than it has right now. I would hope that you would welcome that letter and would allow for that to continue.

Secretary LEAVITT. I will look forward to receiving your letter.

Chairman RANGEL. Ms. Schwartz is recognized for 3 minutes.

Ms. SCHWARTZ. Thank you, Mr. Chairman.

Mr. Secretary, I appreciate, I think, our shared aspiration, although we might state it more directly, to get more Americans health coverage. But you have heard several of us ask this question. I am going to try it in a different way, and I think you may be able to answer these in just yes/no questions.

It does certainly appear and it is certainly clear that your plan is going to do a few things. It is going to create incentives, tax incentives, in a way, for employers to reduce their benefits. If they have comprehensive benefits for their employees, they are being encouraged—because there will a cap on how much tax deduction they will get—to reduce those benefits to a more basic level. Is that correct?

Secretary LEAVITT. No.

Ms. SCHWARTZ. Well, all right.

Secretary LEAVITT. You wanted yes/no. That was no.

Ms. SCHWARTZ. All right. That is fine. I disagree with that. There is no question, and Mr. Doggett talked about this, that 30 million Americans will, as you point out because that is the 20 percent, will have to pay more in taxes—

Secretary LEAVITT. If they have choices.

Ms. SCHWARTZ [continuing]. if their employers provide a more comprehensive package of benefits, so that the intention here is to drive down the package of benefits offered to employees from a more comprehensive to a more basic.

Now, I think what you would say is that you are doing that to shift that to individuals, that cost, that tax increase for 30 million people. That money will be used, theoretically, to enable individuals to be able to buy in the private marketplace if they can afford to do so. Right? That is the way it is going to work?

Secretary LEAVITT. Well, you articulated my position well. But may I also say that they have choices. They can, obviously, look for a policy that will allow them to have a lowered premium.

Ms. SCHWARTZ. That is right. So, it is more basic and more out of pocket so that more Americans, if they can find coverage in the individual marketplace, will be paying more out of pocket, getting a more basic, less comprehensive policy.

Secretary LEAVITT. Ms. Schwartz, Governor Rendell is working very hard with us to try to find a means of making certain that every Pennsylvanian has access. He is going to run into a very serious problem, and it is the one we are describing, and we have got to find a solution to it.

If this isn't the one, then let's find a solution to it. But we believe this offers a very viable way in which people—where we can overcome a policy that is 75 years old, was never voted on, doesn't make any sense at all. It is indefensible for us to give this benefit to one group and not to another.

Ms. SCHWARTZ. I think our time is up. But let me just say that many of us would agree that individuals need help if they are not covered under employers. There is no question about that. But how you do it actually seems to hurt more people and help very, very few.

So, certainly we look forward to working together, if we can, to in fact make sure we are helping more Americans who can't afford health insurance.

Secretary LEAVITT. That is the solution we are after.

Ms. SCHWARTZ. Thank you for your indulgence, Mr. Chairman.

Chairman RANGEL. Would Mr. Davis care to inquire?

Mr. DAVIS. I would care to. Thank you, Mr. Chairman.

Let me, Mr. Secretary, pick up on Ms. Schwartz's point and Mr. Levin's point and Ms. Tubbs Jones' point. One of the major arguments that we are having today deals with how progressive the President's proposal will amount to being in practice.

The Ranking Member and I believe you made the observation during your opening statement that one of the salutary aspects of this plan is it will simply create liability on those who are well-heeled, those who are able to bear the burden. Several of my colleagues have made the point that it is not as simple as that. Ms. Tubbs Jones made the point that there may be certain low wage industries with high value plans because of the risk level of those industries.

I would ask you this question: With respect to the 20 percent that the Administration estimates will have a greater tax liability, what percentage of that 20 percent make over \$100,000 a year?

Secretary LEAVITT. First let me—

Mr. DAVIS. Well, I have a limited amount of time. So, give me a number. What percentage make over 100,000?

Secretary LEAVITT. I don't know the percentage. But may I just say that the assumption you are making of risk being higher in certain industries, that is true in worker compensation. But worker compensation claims are excluded—

Mr. DAVIS. Well, again you are diverting a little bit from my question.

Secretary LEAVITT. What was the question again? I just want to—I got diverted by—

Mr. DAVIS. Right. Well, let me again try to frame it as succinctly as I can. The 20 percent that you estimate will pay higher taxes, give me a sense of their income. What percentage of that 20 percent make over \$150,000 a year, for example?

Secretary LEAVITT. If you divide income stratas into five, those who are in the bottom four income stratas will be affected positively. Those in the top strata would be the ones who are affected negatively. It is a progressive—

Mr. DAVIS. What I think is problematic about that, Mr. Secretary, it is an assumption. I am not sure we have facts to bear it out because it stands to reason there are people who are making 50-, 60-, \$70,000 a year—that is middle class today—who for whatever reason may be working for companies that give them very generous plans.

So, I would ask you this question: If the Administration wants to make this plan as progressive as possible, why not simply do something analogous to what we do with Social Security? Why not tax health benefits for people making over a certain amount of money?

Secretary LEAVITT. Our objective is to solve a problem that the states can't solve on their own.

Mr. DAVIS. Wouldn't that enable you to solve the problem, and wouldn't it be more progressive than what you propose?

Secretary LEAVITT. If you have got ideas on how to solve it, we welcome them. We have given you ours. We believe that it is indefensible for us not to be treating—

Mr. DAVIS. Let me slip in one other quick question with the seconds left. Obviously, I am assuming the \$15,000 exclusion will shift based on CPI every year. There is one problem with that, though, Mr. Secretary.

If you look at what has happened to the value of plans in the last 10 years, you have had increases from \$5700 per family to \$11,500 per family, 2200 individual to 4400 individual. Obviously, the cost of medical inflation is greater than the normal CPI.

So, whatever plan we were somehow to arrive at, I am sure you would acknowledge that we couldn't just use the normal CPI. We would have to have a special health care inflation index. Otherwise, we have got something like an AMT type scenario again.

Secretary LEAVITT. I acknowledge the fact that medical inflation is different than CPI. We can argue as a policy matter whether that is right or wrong. What we both can agree is that we have got to—I hope that we can solve this problem to do away with this inequity so we can get on with the business of having Governor

Rendell and Governor Riley come up with a plan that will insure every person in your state, and they won't have to be discriminated against in the way they are now.

Chairman RANGEL. Dr. McDermott is recognized for 3 minutes.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Governor, I think it is always important not to forget where you came from. As I listen to this whole testimony today, I feel like you are in the position of Colin Powell when he went up to the United Nations, trying to carry out what the President said.

The President said in the State of the Union that his goal was to care for the poor, the elderly, and the disabled. Then you look at this budget that you are up here trying to defend, and I realize as a former Governor it must be very difficult to sit out here and give these kinds of answers.

You know about community development block grants. If you cut \$500 million across the country, what do you say to the Governors about the money? Just raise it from somewhere else? It is not my problem? We don't care? What will be your line with them?

Secretary LEAVITT. Well, I have actually had this conversation. I think the last time I was here, you had a letter from me as the head of the NGA saying, this is not a good idea. Yes. It has suddenly become a good idea. Here are the reasons. First of all—

Mr. MCDERMOTT. You really have reversed your position 180 degrees.

Secretary LEAVITT. The circumstances have changed, not only my role but—

Mr. MCDERMOTT. The President has sent you up to the United Nations defending it. Right?

Secretary LEAVITT. At the time, when I was writing that letter as Chairman of the National Governors' Association, the states were in a much different financial situation than they were today.

I have had this conversation with Governors, and I have pointed out to them that there are categorical grants in almost every area they are using it in. It is not the most efficient way for us to deal with states.

Mr. MCDERMOTT. So, the answer is it is not the most efficient way, and so you are on your own? That is basically what you are saying on behalf of the President of the United States to the Governors.

Secretary LEAVITT. Well, they are not on their own.

Mr. MCDERMOTT. You are on your own to raise the money for these programs.

Secretary LEAVITT. We are increasing money in areas that they do—I mean, we just gave them a lot of money with respect to pandemic preparedness, much of which displaced money that they were using their categorical grants for. We are giving them money in many different areas.

This came in to—this is a decision that I ultimately made, that if we are going to be balancing the budget by 2012, and I am going to hit my balanced number, I have got to find the places that we are funding in duplicate in the system.

Mr. MCDERMOTT. To heck with the program.

Secretary LEAVITT. This is one.

Mr. MCDERMOTT. Basically, what you are saying is you are at the county fair, and I have got a shell game here, and I am going to move some money from over here to over here. Those people over there, they are just—I am sorry, we have got to hit our budget number.

Secretary LEAVITT. No. I am saying we will pay you once but we shouldn't pay you twice for the same thing. We are paying you twice for some of this. I recognize that it is a nice thing for Governors to get money from the Federal Government, but there ought to be a way that—

Mr. MCDERMOTT. Give me one example where you are paying twice for the same thing.

Secretary LEAVITT. I will give you—most of the money—

Mr. MCDERMOTT. If you are leaving 300,000 children without child care in this budget because you are flatlining child care, what child are you paying twice for?

Secretary LEAVITT. Well, the fact that we have half as many children now—let me restate that. We have now removed from the welfare rolls more than half the families, and we have twice the amount of money that we started with in 1996.

Mr. MCDERMOTT. But the Governors say this is going to be 300,000 people, 300,000 children, without child care.

Secretary LEAVITT. I have not heard the Governors say that. What I have heard them say is that they would value having all the money they can get, and who wouldn't.

Mr. MCDERMOTT. It is actually—I am corrected by staff. It is an estimate in your budget. Look at your budget. It says, we estimate 300,000 will not be covered.

Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Meek of Florida is recognized for 3 minutes.

Mr. MEEK. Thank you, Mr. Chairman. Mr. Secretary, thank you for coming before the Committee.

I can say, of what I have seen of your testimony, that before you went a capella on how you felt at the top of the hearing about some of the comments that were made, I just—I really don't want to pose the question because I know there is a difference in opinion. My colleague just before me took the question the way of your previous life as a Governor and having to deal with the issue of the evolution of taxation.

I would even—you know, when we cut taxes here, we put it on you and you have to balance. Then you have to pass it on to local government. Some of the issues that I am looking at here just in your budget, thinking about compassionate, programs that are funding that are proposed to be eliminated are things like emergency medical services for children. That is looking to—set to be eliminated or proposed to be eliminated in the budget.

I am not even from the rural part of this country, but the budget slashes, Health Resources and Services Administration, rural health programs by \$143 million, and moves on—also that slashes the children's hospital graduate medical education program by 187 million, there are a lot of issues here that can assist states.

As a Member of—8 years in the state legislature in Florida, we had to try to kind of figure out, once we get this new method from

or the philosophy from the Federal Government, how we are going to meet the needs of the people that live in our states and local communities.

You mentioned at the beginning of your testimony of trying to deal with it like a leaner agency. This is something that is very difficult, I know, for you and also for the Administration. But it is going to be very difficult us to even try to work together.

I am big on bipartisanship, and I am big on making sure that we can have a budget that everyone can vote on. I am hoping that it is not one of the most partisan votes that we take in the 110th Congress.

But these ideas are something of grave concern to me. Even in Medicare, cutting back on the investment there over the next 10 years by 252 billion. Can you kind of elaborate a little bit on how we make these choices?

Secretary LEAVITT. Sure. Mr. Meek, you and I share having some time in state government. We probably even have some common friends from our days in state government. So my guess is you reflect back, as I do occasionally, and watch what they are doing.

You are probably aware of the substantial surplus that Florida has this year in their budget, just like I am with the budget in Utah. I guess my point is, when we talk about these reductions, it doesn't necessarily mean that they are not—these services aren't going to be provided. It is a question of who pays. What is the partnership? What is the percentage that comes from the Federal Government and what is the percentage that comes from the state?

That is what this conversation is about. The same with the child care. It doesn't mean that child care isn't going to be funded. It is a function of who is going to pay for it.

Mr. MEEK. Well, Mr. Secretary, in closing—I see the red light—I just want to say, as it relates to Florida, the issue of hurricanes, things of that nature, rainy day funds, I mean, if we are talking about folks going into emergency funds trying to meet the needs that we are cutting here, that is something for further review.

But Mr. Chairman, I want to thank you for the latitude. Mr. Secretary, I look forward to working with you through this process.

Secretary LEAVITT. Thank you.

Chairman RANGEL. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Secretary Leavitt, thank you once again for being with us today and persevering through 2 hours of questions from all our Members. We did get all our Members in, and we appreciate very much your staying around for us to complete that ask.

I would just conclude, Mr. Chairman, by saying that there are—we have talked a lot about the Administration's proposal for the standard health deduction today. There have been some good questions asked by Members who have legitimate concerns about the application of that.

I would add, though, that there are a lot of considerations that we did not talk about today. We should talk about those other considerations, which are—among those are cost of health care and cost of health care going up at a much faster pace than general inflation.

A lot of these so-called comprehensive plans that some Members have talked about today are in union shops with big corporations. While those are great—they're wonderful to have, and I know that people who have those don't want to pay more taxes—the fact is that it is becoming more and more difficult for our American-based corporations to come up with the wherewithal to provide those comprehensive health benefits. They are becoming less and less competitive in the world market because of that burden that other countries don't put on their employer communities.

So, those are all questions that are intertwined with this Administration effort to treat more equitably the tax benefits of health care in this country. So, it was a good discussion today. We need to have more and get into some other tangential areas that are certainly relevant to this discussion. Thank you.

Chairman RANGEL. Well, the Secretary has certainly generously offered to meet with us without the benefit of the 5-minute rule, which is restrictive. We accept that. As you well know, many of the Members had questions that they could not get answered today, and if the Secretary would agree, I would like the record to remain open until such time as you could respond to written questions from the Members.

Secretary LEAVITT. Yes.

Chairman RANGEL. We look forward to working with you. These are difficult times, but if you are willing, we are.

Secretary LEAVITT. We are willing.

[Whereupon, at 12:12 p.m., the hearing was adjourned.]

[Questions submitted by the Members to the Witness follow:]

Chairman RANGEL. Questions for the Record

Question for Secretary Leavitt from Chairman Rangel:

A table in the Administration's Budget (on page 375 of the Analytical Perspectives) highlights the number of children who will receive Federal child care coverage under the budget reconciliation bill that passed Congress last year. It shows a drop of 300,000 children receiving child care assistance within five years compared to fiscal year 2006. This basically reaffirms our previous concerns that the modest increase in child care funding provided in the Deficit Reduction Act was insufficient to keep pace with inflation, let alone the new work requirements for welfare recipients.

1. How do you expect States to place more welfare recipients into work activities when Federal funding for child care is covering fewer and fewer families?
2. Do you expect States who are unable to cover the huge shortfall in Federal child care funding to cut programs for needy families? If this were to occur, do you anticipate that States would likely cut child care services to the working poor families first?

Mr. PASCRELL. Questions for the Record

Congressman Bill Pascrell, Jr.

Question for the Record.

Feb. 8, 2007

WTM Hearing

Secretary Leavitt:

Over the past several years, I have closely followed the news on avian influenza and the devastation that could be wrought by a pandemic influenza outbreak, and I continue to be concerned at our own state of preparedness - or lack thereof. A pandemic could be a disaster of the proportions of Hurricane Katrina - but affecting every part of the country at once, not just Louisiana, Mississippi, and Alabama.

In 2005, President Bush proposed the \$7.1 billion National Strategy on Pandemic Influenza (NSPI), and over the last two years, he has sought \$6.1 billion for its implementation. To date, Congress has fulfilled the President's budget requests, appropriating \$6.1 billion for implementation of the National Strategy, most recently as part of the FY06 emergency supplemental bill. In his FY08 budget, the President has requested an additional \$870 million for the National Strategy.

Notwithstanding the allocation of this massive amount of funding, I am worried we are not where we should be on preparedness, especially in securing influenza countermeasures.

You have set a goal for the United States to have a stockpile of antivirals sufficient to treat 25 percent of our population - 81 million people - in line with WHO recommendations and the practices of other nations around the globe. You expect the federal government to stockpile 50 million courses of treatment, and count on the states to buy the remaining 31 million.

For the federal stockpile, I understand that HHS has only ordered 38 million courses to date. I am troubled we haven't yet achieved our goal, and I am worried that the government isn't showing a sense of urgency commensurate with the threat posed by a pandemic.

Here are some of the things I'd like to know:

- When will you order the remaining medications to get us to 50 million courses of treatment, which is the objective you set for the federal government?
- When will all of those medications be delivered and stockpiled for use?
- Do you have the money you need to complete the 50 million purchases from among the \$6.1 billion appropriated to date?
- Are you saying that you have spent all of the \$6.1 billion already?
- Did Congress do anything to tie the hands of the Administration on the use of these funds, to limit them to just antivirals or just vaccines, or have you decided you've spent all you care to on antivirals, but still have money in reserve for other purposes?
- Since the \$870 million you request would flow through the FY08 appropriations process, which won't be finished until at least October 2007, isn't that proof that you are slow-walking our preparedness efforts?
- Why don't you seek this funding in the Supplemental Appropriations bill that the President is about to send us, which would probably be passed in the first half of this year?

Bill Pascrell
N.J.S.

Follow up question on state stockpile

The National Strategy is also counting on states to purchase 31 million courses of treatment. My home state of New Jersey has ordered 830,000 courses of treatment, and has found the funds to complete those orders. However, I understand that New Jersey is one of only 29 states and Puerto Rico to place orders to date, and that total orders only account for about 10 million courses of treatment.

I am concerned that the remaining 21 states haven't placed orders yet, and that many states don't have the funding to complete orders they make, which will leave us far short of the 31 million courses of treatment we need.

- To the best of your knowledge, how many states have purchased drugs to date?
- How many courses of treatment have been delivered?
- By what date do you expect all the states to purchase their drugs, and have them delivered, so we have the entire 31 million dose state stockpile?

[Submissions for the Record follow:]

**Joint Letter of Barbara Crane, and Laura Cohen,
Clinician Task Force, Hartford, CT**

Clinician Task Force
Hartford, Connecticut
February 13, 2007

House Ways and Means Committee

Dear Sirs:

Clinicians (e.g. physical and occupational therapists) involved in the evaluation and recommendation of powered wheelchairs are very concerned with the Administration's proposed FY 2008 budget proposal that would change Medicare payment for powered mobility devices. Specifically, the proposed policy would eliminate the first month purchase option that beneficiaries typically exercise when they qualify for a power wheelchair.

The Clinician Task Force is a group of 30 Physical and Occupational therapists and experts in Wheelchair Seating and Mobility. Clinicians are very concerned about the negative impact on patients that will result if this proposed provision in the Administration's FY 2008 budget were implemented. Concerns are specifically related to the provision that would eliminate the option for beneficiaries to purchase power wheelchairs at the time they are initially furnished.

Beneficiary access to power wheelchairs will be substantially reduced

Clinicians and beneficiaries are currently adjusting to significant changes and challenges as a result of recent changes to the Medicare power mobility device benefit, including new codes, new coverage rules, new documentation requirements and new fees. The provision in the President's proposed budget will result in inadequate access to appropriate power wheelchairs for Medicare beneficiaries with disabilities.

Many power wheelchairs are individually configured to meet the specific needs of one individual. A significant amount of time is spent assessing the needs of the individual. Currently, other payers as well as Medicare, reimburse for these devices either as an upfront purchase or a day-one purchase option. Eliminating the first month purchase option would severely limit beneficiary access as the supplier will be unable to cover the significant upfront product and service costs associated with the provision of power wheelchairs for Medicare beneficiaries. It could conceivably take up to 10 months for the supplier to recover all of the upfront costs. The rehab technology industry cannot afford to absorb these costs and the high level of financial burden would be unsustainable.

Under the proposed provision, the individual configuration for many power wheelchairs would result in the components of the powered mobility device package falling into two different payment categories. That is, part of the device would be paid in lump sum purchase amounts, and part would be paid in monthly rental installments. The power wheelchair base would be subject to the 10-month capped rental rule while all other components; i.e., cushions; back; powered seating options (like

power tilt, power recline, etc) postural components and alternative controls would be categorized under the “inexpensive or routinely purchased” payment category for DME. The financial and logistical problems caused by this split in payment categories will further negatively impact suppliers.

Recommend Moving Power Wheelchairs to Different Payment Category

The current requirement for items to be placed in the “inexpensive or routinely purchased” payment category is evidence that the item is purchased at least 75 percent or more of the time. Currently 100 percent of rehab power wheelchairs, and over 95 percent of power wheelchairs overall, are purchased in the first month because beneficiaries who need these devices have a long-term (life) need for it. Medicare should either maintain the current first month purchase option for power wheelchairs or move them to the “inexpensive or routinely purchased” payment category for DME.

Thank you for careful consideration of these comments. Please call upon us if we can provide any additional information.

Sincerely,

Barbara Crane and Laura Cohen
Co-coordinators of the Clinician Task Force

Statement of National Coalition for Assistive and Rehab Technology

The National Coalition for Assistive and Rehab Technology (NCART), on behalf of its provider and manufacturer members, appreciates the opportunity to submit a statement for the record regarding a proposal in the President’s budget. NCART is a coalition of suppliers and manufacturers of assistive and rehab technologies. The coalition’s mission is to ensure proper and appropriate access to rehab and assistive technologies, which CMS classifies under durable medical equipment (DME).

The President’s budget includes a recommendation that would “establish a 13-month rental period for power wheelchairs”. Currently Medicare beneficiaries are provided a choice between a day-one purchase option and a 13 month rental period when a physician prescribes a power wheelchair. Removing the choice of the day-one purchase has implications for the continuing ability of Medicare beneficiaries to access power wheelchairs.

There are significant upfront costs associated with the provision of complex power mobility systems. Beneficiaries with disabilities often require wheelchairs that the supplier must individually configure to meet the unique needs of that beneficiary. These unique needs may arise due to anatomical anomalies, seating or positioning needs, or the need for alternative drive mechanisms for individuals who cannot use a traditional joystick. Assessing these unique needs entails a significant service component. Moreover, it is often necessary for the supplier to provide demonstration equipment to determine if the equipment meets the functional and medical needs of the beneficiary. These costs of assessing the beneficiary, providing the demonstration product and the actual equipment cost are significant and are borne by the supplier prior to submitting a claim to Medicare.

New quality standards and recent changes to coverage guidelines for power mobility are increasing supplier costs. CMS has issued new quality standards that suppliers must meet in order to participate in the Medicare program. These quality standards mandate that in order to provide complex rehab and assistive technology to Medicare beneficiaries the supplier shall employ at least one qualified Rehab Technology Supplier (RTS) or be certified as a RTS per location. A qualified RTS is an individual that is or has one of the following credentials: Certified Rehab Technology Supplier (CRTS), Assistive Technology Supplier (ATS); or Assistive Technology Practitioner (ATP)”. In addition, The Rehab Technology Supplier shall have at least one or more trained technicians available to service each location appropriately depending on the size and scope of its business.

CMS’s coverage policy for power mobility devices (PMD) implemented last year requires that by November 2008 suppliers providing complex rehab power mobility products must have an ATS on staff that is directly involved in the selection of the wheelchair for the individual.

NCART worked closely with CMS and its contractors to develop the quality standards and coverage requirements. We believe these requirements are essential in any effort to ensure the best clinical outcome for individuals who require the use of this

technology. However, it is important to understand that these changes requiring specialized staffing will bring additional cost to suppliers of this technology.

There have been myriad changes to the power mobility benefit over the last two years starting with the requirement in the Medicare Modernization Act (MMA) that beneficiaries have a face-to-face evaluation by a physician in order to qualify for a device. In addition, the new PMD policy requires that the beneficiary be evaluated by a physical or occupational therapist if they need a complex power mobility device. The supplier is required to perform a home assessment to ensure that the home is accessible for the recommended device. The supplier is also required to collect significant information from the patient's medical record to maintain on file and available to Medicare on demand. These changes have also increased the cost of providing power mobility devices.

Additionally, the PMD policy implemented approximately 60 new HCPCS codes. CMS issued new Medicare fee schedules for these new codes. The result of the methodology used to develop the new fee schedule was a significant reduction in reimbursement for power mobility devices. Moreover, the coding changes have also required suppliers to provide substantial education to their referring physicians and clinicians in order to ensure that they understand the new coding and coverage guidelines and that the documentation developed is accurate and adequate to meet Medicare's coverage requirements.

Medicare beneficiaries prefer to purchase their power mobility devices when their need is long-term. Historically, over 95 percent of Medicare beneficiaries chose to purchase their power wheelchair when given the option upfront. The current definition within the Medicare guidelines for the category "inexpensive or other routinely purchased DME" states, "Routinely purchased DME is defined as equipment acquired by purchase at least 75 percent of the time. Data from the Statistical Analysis Durable Medical Equipment Regional Carrier indicates that power mobility devices exceed this requirement.

Because of the numerous and significant upfront costs detailed above that must be borne by the rehab and assistive technology supplier, the supplier may be unable to provide the power wheelchair when reimbursement is spread over several months rather than when it is initially ordered. Suppliers would be unable to pay manufacturers for the power wheelchairs when invoices become due because of the delay in the purchase and receipt of money from the Medicare program. Suppliers would have to absorb significant upfront costs, as they would receive payment only over a 13 month period for their large initial investment. Thus, beneficiary access to power wheelchairs may be affected as suppliers will be unable to cover their significant upfront costs associated with providing power wheelchairs to Medicare beneficiaries.

NCART strongly advises that the option to purchase power wheelchairs continue to be available to Medicare beneficiaries. If a 13-month rental is mandated, access will be denied to the neediest of Medicare beneficiaries.

Statement of National Registry of Rehabilitation Technology Suppliers

The National Registry of Rehabilitation Technology Suppliers (NRRTS) submits the following written comments regarding proposals contained in the President's budget for Health and Human Services for 2008. NRRTS is a registration organization for professionals involved in the provision of direct care and service for rehab and assistive technology devices and services to people with significant neuromuscular and musculoskeletal disabilities.

NRRTS is extremely concerned about a recommendation in the President's budget that would "establish a 13-month rental period for power wheelchairs". Currently Medicare beneficiaries are provided a choice between a day-one purchase option and a 13-month rental period when a physician prescribes a power wheelchair. Steps to remove the choice of a day-one purchase will be problematic for many Medicare beneficiaries.

The best practice standard of our industry and profession is that custom Powered Mobility Devices (PMDs) and other Complex Rehab and Assistive Technology product are not rented to clients—they are sold—including in the price the added value of appropriate evaluation, product selection, fitting, face-to-face delivery, follow-up and service. If the President's budget proposal is accepted as written, allowing for rental only for PMDs, then only the most generic products will be available that won't necessarily meet the complex needs of needs of Medicare beneficiaries with significant physical and functional impairments. Access to appropriate PMDs will

inevitably be denied by this policy. We do not believe that this is the President's intent.

Due to significant upfront costs and increased cost resulting from recent policy changes, Medicare beneficiaries will lack adequate access to power mobility devices if a 13-month rental is required.

There are significant upfront costs associated with the provision of complex power mobility systems. Individuals with disabilities often require wheelchairs that are configured specifically to meet their unique needs. This need may arise due to anatomical anomalies, seating or positioning needs, or the need for alternative drive mechanisms for individuals who cannot use a traditional joystick. There is a significant service component associated with assessing an individual's needs. It can often involve simulation to ensure that the technology that is being recommended will adequately meet the needs of the individual. These costs plus the significant equipment cost is borne by the supplier prior to submitting a claim to Medicare.

Recent changes to quality standards and coverage guidelines for power mobility are increasing supplier costs. These new quality standards mandate that in order to provide complex rehab and assistive technology to Medicare beneficiaries" the supplier shall employ at least one qualified Rehab Technology Supplier (RTS) or be certified as a RTS per location. A qualified RTS is an individual that is or has one of the following credentials: Certified Rehab Technology Supplier (CRTS), Assistive Technology Supplier (ATS); or Assistive Technology Practitioner (ATP)". In addition, The Rehab Technology Supplier shall have at least one or more **trained technicians** available to service each location appropriately depending on the size and scope of its business.

The coverage policy for power mobility devices (PMD) implemented in November of 2006 requires that by April 2008 suppliers providing complex rehab power mobility products must have an ATS on staff that is directly involved in the selection of the wheelchair for the individual.

Representatives of our industry and profession have worked closely with CMS and its contractors to develop these requirements and believe these requirements are essential in any effort to ensure the best clinical outcome for individuals who require the use of this technology. However, it is important to understand that these changes will bring additional cost to suppliers of this technology.

There have been numerous changes to the power mobility benefit over the last 2 years starting with the requirement in the MMA that individuals have a face-to-face evaluation by a physician in order to qualify for a device. In addition, the new PMD policy requires that the individual be evaluated by a physical or occupational therapist if they need a complex power mobility device. The supplier is required to perform a home assessment to ensure that the home is accessible for the recommended device. The supplier is also required to collect significant information from the patient's medical record to maintain on file and available to Medicare on demand. These changes have all increased the cost of providing power mobility devices.

Additionally, the PMD policy implemented approximately 60 new HCPCS codes and a new Medicare fee schedule was developed for those codes. The result was a reduction in reimbursement for power mobility devices. The coding changes have also required suppliers to provide substantial education to their referring physicians and clinicians in order to ensure that they understand the new coding and coverage guidelines and to ensure that documentation developed is accurate and adequate to meet Medicare's coverage requirements. Again, this has increased cost to suppliers.

Medicare beneficiaries prefer to purchase their power mobility devices when their need is long-term. Historically, over 95 percent of Medicare beneficiaries chose to purchase their power wheelchair when given the option upfront. The current definition within the Medicare guidelines for the category "inexpensive or other routinely purchased DME" states, "Routinely purchased DME is defined as equipment acquired by purchase at least 75 percent of the time. Statistical data from the SADMERC proves that power mobility devices exceed this requirement. Currently, Medicare beneficiaries have the option of renting their power wheelchair if they prefer.

NRRTS strongly advises that the option to purchase power wheelchairs continue to be available to Medicare beneficiaries. If a 13-month rental is mandated, access will be denied to the most needy of Medicare beneficiaries.