DEPARTMENT OF HEALTH AND HUMAN SERVICES BUDGET PRIORITIES FOR FISCAL YEAR 2005

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BEFORE THE

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HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES BUDGET PRIORITIES FOR FY 2005

THURSDAY, FEBRUARY 26, 2004

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:10 a.m. in room 210, Cannon House Office Building, Hon. Jim Nussle (chairman of the committee) presiding.

Members present: Representatives Nussle, Shays, Gutknecht, Ryun, Hastings, Putnam, Wicker, Tancredo, Bonner, Garrett, Barrett, Spratt, Moran, Hooley, Baldwin, Moore, DeLauro, Scott, Capps, Thompson, Baird, Cooper, Emanuel, Davis, Majette, Kind, and Edwards.

Chairman NUSSLE. Good morning and welcome, everyone, to this hearing in the Budget Committee. I am pleased to have with us today the Secretary of the Department of Health and Human Services for a return visit, the Hon. Tommy Thompson, to discuss the key elements of the Department's request for this year's budget.

Secretary Thompson, welcome back to the Budget Committee, and we are honored to have you with us today. We know that you have a prior commitment, that you need to leave at noon; making a very important journey, as I understand it, to Iraq. So it is important that we have a chance to visit with you and let you get on to some other important business.

While the Department of Health and Human Services has a long list of responsibilities and certainly numerous agencies within its jurisdiction, there are three areas that I believe are important to focus on today: Medicare reform and prescription drugs; the health savings accounts, and, of course, the new efforts with regard to counteracting bioterrorism.

Last year the Congress and President Bush accomplished a feat that policymakers have struggled with for years. We enacted legislation to strengthen Medicare and include a first-ever prescription drug benefit. While the new law may not be a perfect solution to the many challenges that confront the Medicare program, it is without question a truly historic first step in strengthening the program, which has really lagged behind private health insurance since its enactment in 1965.

The benefits of this action are really already on their way. According to the Centers for Medicaid and Medicare Services, in just 4 months all beneficiaries will have access to a Medicare discount card that will result in about 10 to 15 percent savings for the average beneficiary, and up to about a 25-percent savings on certain

prescription drug costs. Low-income seniors will also be receiving a $600 subsidy in conjunction with their prescription drug discount card, which is really welcome relief to so many, I know, of my constituents that I met with this last week during the President's Day recess.

In addition to the inclusion of the prescription drug benefit, there are a host of other positive changes to Medicare that I think are worth noting. We strengthened its financing by addressing waste, fraud and abuse, which I am proud to say was an effort that at least had some of its beginning and momentum from this committee last year as part of our budget process; reforming the regulatory structure to ease the burden on Medicare providers, making it easier for generic drugs to enter the marketplace; and, finally, addressing the payment and equity that has been there with regard to rural and urban areas that certainly you, as Governor of Wisconsin, and I know well from Iowa, it is an issue of particular concern to many of us on this committee. And I have seen some studies that finally show Iowa out of last place, which I can tell you my constituents were very happy about.

As part of the improvements in both benefits and the way Medicare program does business, the Congress and the President have also enacted transformation in the way that we can manage health care needs. Now, much like Americans save for their own and their family's future through IRAs and 401(k)s and education savings accounts and the like, we have enacted the opportunity for people to save for their own medical needs through health savings accounts. These accounts will not solve every problem in health care, certainly, but it will allow for two very important changes. First, they will restore to consumers the ability to plan for and make their open choices, which is huge in health care for so many people. And secondly, it will help address some of the long-term demographic and financial problems facing the Medicare program.

While a discussion of these changes will likely consume the bulk of the hearing, I don't mean to forget probably one of the most important new roles and expanding roles for the Department, as we are all aware of the ongoing threat to our Nation from a potential and continuing bioterrorist attack.

Secretary Thompson, you and your Department have been charged with ensuring that we are prepared with the necessary training, supplies, and vaccines to protect our citizens in the event of such an incident. Mr. Secretary, I am eager to hear about the progress that the Department has made on these fronts in the past few years and also your thoughts on what also may need to be done to ensure our safety.

I want to also ensure that we talk about Medicare enactment, and if there are challenges or changes that we need to be working on in order to ensure that the Medicare changes that we have enacted last year can be put into effect as quickly as possible so that we can make sure that the benefits from this act are able to be taken advantage of as quickly as possible.

So I appreciate you being with us today. Your entire testimony will be made part of the record, and at this point I would turn to Mr. Spratt for any comments he would like to make.

Mr. SPRATT. Mr. Secretary, thank you very much for coming and discussing one of the biggest components on the domestic side of our budget—probably the biggest—and for taking time out of what has to be a phenomenally busy schedule to answer our questions about this program.

Mr. Secretary, one of the surprises in the budget this year was the revelation that the Medicare prescription drug benefit, passed just a few months ago with a basically Republican majority, was going to cost $534 billion, $139 billion more than was advertised at the time it was passed.

Had that cost estimate been disseminated and available to Members of the House of Representatives, particularly on the other side of the aisle, I don't think it would have passed, not at $539 billion.

And had that price for the rather meager coverage been advertised, then I think everybody might have been compelled to go back and look at the bill and look at one extraordinary provision in that bill which prohibited the government from negotiating drug prices with pharmaceutical firms. For the first time in the 21 years I have been in Congress, this bill contained a provision which said to offices of the government, you don't have the obligation, indeed you are not allowed to go seek the best price for the U.S. Government. Not only is it bad policy, it is expensive policy, and it is certainly not a precedent we want to follow elsewhere.

Now we received word recently, the Wall Street Journal had a story of which I am sure you are aware, indicating that several States who are in the business of buying drugs for Medicaid—I think the drug bill for all the Medicaid, State and Federal, is $27.5 billion last year, a big number—they are out trying to form purchasing pools themselves, among themselves, using pharmacy benefit managers so that they can negotiate down with the prices. And they have been called to account and told that this might not conform to Federal law. Well, great. I would like to see—we want clarification of that today.

And probably the only way to break the phalanx and the existing circumstances of these prices is to allow some importation so there is some competition for the domestic prices, but we don't have much assurance that that is going to happen either. Surely we don't want to add to all of the other aspects of this problem a prohibition on the States. We ought to be encouraging the States, telling them to get out and negotiate lower drug prices, that we will readily approve any kind of reputable and well-set-up proposal.

Let me show you just a few charts to get the debate going, Mr. Secretary, that we will be talking about today. The President's budget, as this chart shows, a simple bar graph that the President's budget will cut HHS, your Department, by about $1 billion this year, for next year.

Next chart. Here are some of the allocations. NIH, a few years ago we resolved, House and Senate, both sides of the aisle, that we would double the budget for NIH over a period of 5 years, and we did it. Now we are beginning to see NIH barely grow with the rate of inflation, and that is bound to have an impact on medical research and breaking the new frontiers of medical research.

FDA, vitally important role. It would be one of the overseers, if we did allow importation to get some drug price competition going, just a 2-percent increase.

And then HRSA, which is basically the community health side of the HHS, this is the organization that provides for community health centers and public health—these are the people who don't have anything, and have to go to the government as a last resort for their health, −2.28 percent. It is a cut over the period of 5 years.

And then the CDC, which was mentioned indirectly by the chairman when he referred to bioterrorism, after 9/11 a number of Members went down to Atlanta to see CDC; and, Mr. Secretary, frankly they were shocked at the condition of some of the facilities there, both in terms of what we can do for this BioShield-type initiative that we are taking and also in terms of what might be mispriced, misallocated or pilfered from that operation down there and put to dangerous uses in our economy.

So we have got a lot to talk about, Mr. Secretary, and I know you have got limits on your time, I don't want to stretch them. But these are some of the things that we want to touch upon, and I hope that is all responded to in the course of the statements you are about to make. Thank you again for being here.

Chairman NUSSLE. Thank you, Mr. Spratt.

I ask unanimous consent that all members be allowed 7 days to submit statements for the record and also, as we have done in the past, as well, questions if we don't get to members, so that the Secretary may, because of his time constraints, answer them in writing.

[The information referred to follows:]

QUESTIONS FOR THE RECORD OFFERED BY HON. DENISE L. MAJETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Thank you Secretary Thompson for coming before us today. You have had a tough time today defending the President's abysmal budget request. It is impossible to defend a budget that shortchanges our children today and our grandchildren tomorrow.

The President's proposal fails to meet today's urgent domestic priorities including making sure our children receive a good education and adequate health care. And as Chairman Greenspan testified yesterday, it will leave our children with crippling deficits far into the future and a truly staggering debt.

This is an irresponsible budget that shortchanges our children's education and health, and then leaves them to pay the check for over 7 trillion in debt. Our children deserve better.

But beyond the big picture Mr. Secretary, I do have some specific questions.

Question No. 1:

Mr. Secretary, as you know, the CDC is based in my district, and like all Americans I am committed to ensuring that this critical agency is adequately funded to perform all that we are asking these professionals to do. This includes their role in public health research and implementation as well as their increasing role in responding to the threat from terrorism.

Our current total national healthcare expenditure (private, federal, state) this year is $1.6 trillion. With the aging baby boomer population and the financial strain of Medicare and Medicaid this number will double by 2012. Chairman Greenspan warned yesterday about the stifling effect increased Medicare spending could have in the future. In light of this, it makes sense to invest more in research and in proven prevention programs to lower these costs.

And in terms of the CDC's other role in fighting biological threats, yesterday CIA director Tenet testified that Al-Qaida's program to produce Anthrax is one of the most immediate terrorist threats we are likely to face.

And yet, the President's budget cuts the CDC's funding by over $400 million this year—furthermore, they would be below today's funding levels 5 years from now. Mr. Secretary, will you support CDC Director Julie Gerberding's professional judgment request, made in May 2003, that CDC's budget should instead be doubled over the next 5 years to fulfill these dual roles?

Secretary Thompson's Written Response

Thank you for the question, Congresswoman Majette. Now, and in future years, I remain fully committed to supporting the important work of the Department's Centers for Disease Control and Prevention. With regard to CDC's fiscal year 2005 budget request, increases of $341 million in various programs were offset by funding of:

- Buildings & Facilities (+$81.5M) to continue construction of the Roybal East Campus Consolidated Laboratory Project (Bldg 106), which will replace and consolidate infectious disease laboratory and vivarium facilities and to complete the Fort Collins Vector Borne Infectious Disease Laboratory which includes insectary, vivarium and diagnostic laboratories (−$179 million below fiscal year 2004 enacted);
- One-time congressional projects (−$44M);
- Extramural prevention research (−$15M) CDC has a growing commitment to extramural public health research broadly, not only research confined to prevention efforts. In an effort to avoid duplication, CDC aims to continue to invest in the extensive rubric of public health research on a coordinated, agency-wide basis.);
- Youth Media Campaign (−$30.8M) The President's fiscal year 2005 budget request for the VERB campaign is $5 million. The fiscal year 2004 funding of $36 million will be used to extend the phase 3 media buy (fiscal year 2003 funds) for the VERB Campaign. In effect, the fiscal year 2004 appropriation increases phase 3 from a $51.3 million to an $87 million campaign and this will also help to ensure continued added value (in-kind) commitments from media partners.); and
- Terrorism redirection (−$130M) Monies that were previously allocated directly to states (−$105 million), for upgrading internal CDC capacities (−$15 million), and the culmination of a seven year research project around anthrax vaccine (−10 million), will be used to fill a preparedness gap in early attack warning and surveillance. The benefits of the new BioSense program, of expanding quarantine stations at US airports, and of enhancements to the Laboratory Response Network will be felt in all state and local health departments. The Nation as a whole will be better prepared to respond to a bioterrorist attack and surveillance and lab capacities at CDC and in the states will be greatly improved.

Question No. 2:

Mr. Secretary, another investment in our future that I would like to address is our investment in education, specifically early childhood education.

Head Start is underfunded this year alone by $1.5 billion and more than a third of eligible children are still being left behind.

And the President's budget will not increase the number of children served by this crucial program.

I'd like to remind everyone, Mr. Secretary, of a few facts about Head Start. Participants in Head Start are:

- Less likely to be held back in school.
- Less likely to be placed in special education classes.
- More likely to succeed in school.
- More likely to graduate.
- More likely to be rated as behaving well in class and being better adjusted in school.
- And five times less likely to end up in jail as adults.

Mr. Secretary, Head Start saves us more than it costs by reducing incarceration rates. Will you join me in fighting to increase funding for this critical program?

Secretary Thompson's written response

The administration agrees that Head Start is a valuable program that has served our Nation's children well over the last four decades. Funding for the program has increased $750 million over the last 4 years. Nevertheless, we believe that it is critical to continue to improve the quality and effectiveness of the program to ensure that every child enters school ready to learn. This can be done by ensuring that all Head Start teachers are trained in the most up-to-date, research-based methods for helping children develop early literacy and numeracy skills that they need in order to be successful in kindergarten. In fact, the Administration has implemented an aggressive plan to make this happen. Over 50,000 Head Start teachers have received training in early language and literacy development and early literacy teaching strategies through our STEP program. Moreover, for the first time, an outcomes-

based system of accountability has been implemented so that weaker programs can be identified and provided with the training and technical assistance that will result in improved language, cognitive, and early literacy outcomes for children participating in those programs. These improvements will not be made at the cost of sacrificing the comprehensive services that are being offered to close to 920,000 children in the program.

However, I disagree with your assertion that nearly a third of eligible children are being left behind, because many families chose other options for their children, including placing the child in State-run pre-K programs, day care centers, or in at-home education with their parents or other family members. Additionally, many Head Start programs have experienced problems in maintaining their funded enrollment levels. In fact, self-reporting by Head Start centers indicates that on average a typical grantee has an enrollment level of only 93.1 percent of funded slots. Nationally, that means that 62,000 eligible children are not receiving Head Start services, yet they should be given current funding levels. The President's fiscal year 2005 budget has proposed a solution by requesting $45 million to fund a demonstration program allowing up to eight States the option of greater coordination between Head Start, State-run pre-K, and child care. This could result in significantly fewer programs with under-enrollment problems and more children receiving a high quality preschool education. Additionally, the fiscal year 2005 budget would provide for an increase in Head Start enrollment of nearly 10,000 children by reallocating a percentage of Head Start discretionary training and technical assistance funding. Together, these efforts will help more children around the country prepare to enter school healthy and ready to learn. We urge Congress to act on both of these requests.

We appreciate Congressional concern on this issue and look forward to working with your Committee to continue to strengthen the Head Start program.

Mr. Secretary, welcome. Your entire statement will be made part of the record, and you may summarize it as you feel necessary. We are welcome to receive your testimony.

STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary THOMPSON. Thank you very much, Mr. Chairman. I applaud you and your leadership and thank you so very much for giving me this opportunity to come in front of you. And if in fact we don't finish up when I have to leave, I would be more than happy to come back if you so desire.

Congressman Spratt, thank you for your leadership as well. I appreciate your figures. I appreciate your comments, and I would like to address several of the things that you have raised in your opening remarks.

I also want to thank all members of the committee for your responsibility and your dedication and your friendship. Thank you for inviting me to discuss the President's fiscal year 2005 budget for the Department of Health and Human Services.

In my first 3 years at the Department, we have made tremendous progress in improving the health, the safety, and the independence of the American people. We continue to advance in providing health care to seniors and to lower-income Americans and improving the well-being of children, strengthening families, and protecting the homeland. We have reenergized the fight against AIDS at home and abroad. We increased access to quality health care, especially for minorities, the uninsured and the underinsured. We are helping smokers free themselves from this debilitating habit through a national quit line which we funded internally in the Department at my request. And with your help, 2 months ago President Bush signed the most comprehensive improvements to Medicare since it was created nearly four decades ago.

To expand our achievements the President proposes $580 billion for HHS for fiscal year 2005, an increase of $32 billion, or 6 percent over fiscal year 2004. Our discretionary budget authority is $67 billion, an increase of $819 million, or a 1.2-percent increase over fiscal year 2004, but an increase of 26 percent over fiscal year 2001 when I took over.

In order to strengthen our bioterrorism preparedness and Public Health System, we have requested $4.1 billion, up from $300 million, in 2001.

I would like to ask all of you and encourage you to take me up on it, to come over and see the war room that we have built at the Department of Health and Human Services. Emanuel has been over and Tammy Baldwin has been over and a couple of you have been over, but it is very visionary. It is probably the most exciting thing for communications and for tracking diseases and storms in the world. And I would invite you to come over at any time. It would be very revealing and would help you in your discussions, I am confident.

This investment will improve preparedness for bioterrorist attack or for any public health emergency. We have already seen your investments pay off in CDC's leadership in fighting the SARS outbreak last year and a coordinated public health response to the West Nile virus. It even helped to deal with a particularly hard flu season this year.

We have also launched our steps to a healthier U.S. campaign—I happen to be passionate about prevention—in order to encourage Americans to improve their health and avoid disease by practicing healthy habits and avoiding risky behaviors.

As you know, I am a big proponent of information technology. That is why we provided a computer language program, SNOWMED, to providers at no charge. We are leading the way in developing standards for electronic medical records. And yesterday morning I announced an FDA rule to prevent medication errors by requiring bar codes on all medicines and blood products and to incorporate preventative practice into Medicare. I worked with members of the committee and with the rest of Congress to provide the most comprehensive update to Medicare since it was created in 1965.

We have preserved the Medicare program and built upon it with better benefits and more choices. These better benefits include prescription drug coverage to save seniors money, improvements in preventative care, which I believe is very, very important, and better access to the doctors and medical care that seniors want.

In many cases benefits will be enhanced immediately. We are already reviewing the new benefit proposals which were submitted by Medicare advantage plans. Let me give you a few examples. Independent Health and Universal Health Care will reduce premiums for Medicare Advantage Plans in New York by 13 to 50 percent. Independent Health also expects to enhance benefits. In Massachusetts, Tufts is cutting premiums from $147 to $80. And members of the Medicare Blue Value Plan of Horizon Blue Cross/Blue Shield of New Jersey will no longer pay the $52 premium.

Overall, we expect 2 million Medicare Advantage beneficiaries will pay lower premiums, 2 million will save money on cost shar-

ing, and 3.4 million will get enhanced benefits. The new law is already at work saving seniors money and increasing their access to modern medicine.

HHS has already completed 76 activities in implemented the MMA, such as issuing the regulation for the discount card only 8 days after the bill was signed. Our centers for Medicare and Medicaid Services have been working with State governments, the Social Security Administration and other partners to identify people eligible for the card, set up communication systems for information sharing, create a price comparison Web site, and review the card provider applications.

Seniors will be able to enroll in the card by May of this year. We will add transparency as well to the prescription drug market by making public the price of each drug under each card. In fact, we will update the prices on our Web site each and every week.

We expect competition among the cards will drive down drug prices, probably significantly, as people compare the prices each card offers for the drugs they typically take. We also press forward with our initiative to improve health care quality by adding home health agencies to the effort launched in 2002 for nursing homes.

Americans can now get comparative quality information about specific home health agencies and nursing homes, and hospitals will be next. Speaking of hospitals, we have made it clear to hospitals that they are welcome to provide discounts for the uninsured and the underinsured.

Through intergovernmental transfers, State governments can share their costs of the Medicaid program with local governments. We believe the Federal Government should be matching true expenditures. Restoring the matching requirements would save $23 billion in the Medicaid program over the next 10 years. While these savings would be significant, that still represents less than 1 percent of what the Federal Government will spend over the next 10 years.

We look forward to working with Congress, the medical community, and all Americans as we build upon our past accomplishments and implement the new Medicare law and carry out the initiatives that President Bush is proposing to build a healthier, safer, and stronger America.

[The prepared statement of Secretary Thompson follows:]

PREPARED STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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

• Since 2001, with the support Congress, the administration has funded 614 new and expanded health centers that target low-income individuals, effectively increasing access to health care for an additional 3 million people, a 29-percent increase.

• The Department established the Access to Recovery State Vouchers program, providing 50,000 individuals with needed treatment and recovery services.

• To support the President's faith-based initiative, HHS has created the Compassion Capital Fund for public/private partnerships to support charitable groups in expanding model social services programs. We awarded 81 new and continuing grants in 2003.

• HHS initiated a new Mentoring Children of Prisoners program to provide one-to-one mentoring for over 30,000 children with an incarcerated parent in fiscal year 2004. The Department also created education and training vouchers for foster care youth, providing $5,000 vouchers to 17,400 eligible youth.

• In August 2001, the President and I invited States to participate in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. States use HIFA demonstrations to expand health care coverage. As of January 2004, HIFA demonstrations had expanded coverage to 175,000 people, and another 646,000 were approved for enrollment.

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

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

Allow me to draw your attention to several key factors of the HHS budget so that we may continue to work together to address the needs of our Nation.

MEDICARE AND MEDICAID REFORM/MODERNIZATION

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

DRUG DISCOUNT CARD

MMA establishes a new, exciting Medicare approved prescription drug discount card program, providing immediate relief to those beneficiaries who have been burdened by their drug costs. From June 2004 through 2005, all Medicare beneficiaries, except those with Medicaid drug coverage, will have the choice of enrolling in a Medicare-endorsed drug discount card program. With the discount card, beneficiaries will save an estimated 10 to 15 percent on their drug costs. For some, savings may reach up to 25 percent on individual prescriptions. A typical senior with $1,285 in yearly drug expenses could save as much as $300 annually. To enroll, beneficiaries will pay no more than $30 annually. Those with low incomes will qualify for a $600 per year subsidy to purchase drugs. Medicare also will cover the enrollment fees for low-income seniors.

VOLUNTARY PRESCRIPTION DRUG BENEFIT

Responding to President Bush's pledge to add meaningful drug coverage to Medicare, MMA establishes a new voluntary prescription drug benefit under a new Medicare Part D. Starting in 2006, Medicare beneficiaries who are entitled to Part A, or enrolled in Part B, can choose prescription drug coverage under the new Part D. Under Part D, beneficiaries can choose to enroll in stand-alone, prescription drug plans (PDPs) or Medicare Advantage prescription drug plans (MA–PDs), and will be able to choose between at least two plans to receive their benefit. The law contains important beneficiary protections. For example, while the plans are permitted to use formularies, they must include drugs within each therapeutic category and class of

covered Part D drugs, allowing beneficiaries to have a choice of drugs. In instances in which a drug is not covered, beneficiaries can appeal to have the drug included in the formulary. To reduce the number of prescribing errors that occur each year, HHS will develop an electronic prescription program for Part D covered drugs.

MEDICARE ADVANTAGE

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

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

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

PROVIDERS AND RURAL HEALTH

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

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

PREVENTIVE BENEFITS

MMA expands the number of preventive benefits covered by Medicare beginning in 2005. Through a particularly important provision, an initial preventive physical examination will be offered within 6 months of enrollment for those beneficiaries whose Medicare Part B coverage begins January 1, 2005 or later. The examination, as appropriate, will include an electrocardiogram and education, counseling, and referral for screenings and preventive services already covered by Medicare, such as pneumococcal, influenza and hepatitis B vaccines; prostate, colorectal, breast, and cervical cancers; in addition to screening for glaucoma and diabetes. Diabetes and cardiovascular screening blood tests do not have any deductible or copayments, as Medicare pays for 100 percent of these clinical laboratory tests.

REGULATORY REFORM/CONTRACTING REFORM

MMA includes a number of administrative and operational reforms, as well. For example, regulatory reform provisions require the establishment of overpayment recovery plans in case of hardship; prohibit contractors from using extrapolation to determine overpayment amounts except under specific circumstances; describe the rights of providers when under audit by Medicare contractors; require the establish-

ment of standard methodology to use when selecting a probe sample of claims for review; and prohibit a supplier or provider from paying a penalty resulting from adherence to guidelines. In addition, MMA allows physicians to reassign payment for Medicare services to entities with which the physicians have an independent contractor arrangement. Under the new law, final regulations are to be published within 3 years, and all measures of a regulation are to be published as a proposed rule before final publication.

Also under the law, as Secretary, I will be permitted to introduce greater competitiveness and flexibility to the Medicare contracting process by removing the distinction between Part A and Part B contractors, allowing the renewal of contracts annually for up to 5 years, limiting contractor liability, and providing incentive payments to improve contractor performance. These changes will enhance HHS efficiency and effectiveness in program operations.

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

MEDICARE AND MEDICAID ESTIMATES

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

When Congress considered this act, Mr. Chairman, CBO estimated the cost of the bill at $395 billion from 2004–13. The HHS actuaries have recently estimated the cost of the law as $534 billion from 2004–13. The CBO Director told the House and Senate Budget Committees that CBO has not changed its estimate and that they continue to believe that the cost of the bill is $395 billion. Because the Medicare legislation makes far-reaching changes to a complex entitlement program with many new private sector elements, there is even larger uncertainty in these estimates than usual.

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

ADDITIONAL MMA CHANGES

MMA addresses other issues facing the Medicare program including the program's long-term, financial security. To contain costs in the Medicare program, the law requires the Medicare Trustees, beginning in the 2005 annual report, to assess whether Medicare's "excess general revenue funding" exceeds 45 percent. As defined in the law, excess general revenue funding is equal to Medicare's total outlays minus dedicated revenues. The Medicare Trustees shall issue a "warning" if general revenues are projected to exceed 45 percent of Medicare spending in a year within the next 7 years. If the Trustees issue such a warning in two consecutive years, the law provides special legislative conditions for the consideration of proposed legislation submitted by the President to address the excess general revenue funding.

In addition to implementing MMA, the HHS budget request includes provisions for the State Children's Health Insurance Program, the New Freedom Initiative, and Medicaid.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

SCHIP was created with a funding mechanism that required states to spend their allotments within a 3-year window, after which any unused funds would be redistributed among states that had spent all of their allotted funds. These redistributed funds would be available for one additional year, after which any unused funds would be returned to the Treasury.

On August 15, 2003, President Bush signed Public Law 108–74. The law restores $1.2 billion in fiscal year 1998 and fiscal year 1999 SCHIP funds, and makes them available to states until September 30, 2004. The law also extends $2.2 billion in fiscal years 2000 and 2001 SCHIP funds, and revises the rule for the redistribution

of the unspent funds from these allotments. For fiscal years 2000 and 2001 allotments, the law allows states that do not spend their entire allotment within the 3-year period to keep half of those respective year's unspent amounts. The other half would be redistributed to states that have spent their entire amount of the respective year's allotments. The law also extends the availability of funds from the fiscal year 2000 allotments through September 30, 2004, and the availability of fiscal year 2001 allotment through September 30, 2005. The law gives some relief to states that expanded their Medicaid programs to cover additional low-income children prior to the enactment of SCHIP.

NEW FREEDOM INITIATIVE

The administration is committed to ensuring that people with disabilities and/or the long-term care needs receive the supports necessary to remain in (or return to) the community as opposed to remaining in an institutional setting. One of the administration's priorities is relying more on home- and community-based care, rather than costly and confining institutional care, for the elderly and people with disabilities. The New Freedom Initiative signifies the President's commitment to promoting at home and community-based care. There are several components to this initiative, Mr. Chairman, which I would like to bring to your attention.

Under the "Money Follows the Individual Re-Balancing Demonstration" states could participate in a 5-year demonstration that finances services for individuals who transition from institutions to the community. Federal grant funds would pay for the home- and community-based waiver services of an individual for one year at an enhanced Federal match rate of 100 percent. As a condition of receiving the enhanced match, the participating State would agree to continue care at the regular Medicaid matching rate after the end of the 1-year period and to reduce institutional long-term care spending.

The New Freedom Initiative is very important to me and to the President, and we would like to work closely with Congress to secure its passage this year. The administration recognizes the success of consumer directed programs that give people the opportunity to manage their own long-term care, as delineated by the development of its Independence Plus Waivers. Thus, we propose allowing individuals who self-direct all of their community-based, long-term care services to accumulate savings and still retain eligibility for Medicaid and Supplemental Security Income. Under current law, beneficiaries are discouraged from accumulating savings because it could jeopardize their eligibility for Medicaid and SSI. Under the Living with Independence, Freedom, and Equality (LIFE) Accounts Program, individuals who self-direct all of their Medicaid, community-based, long term supports will be able to retain up to 50 percent of savings from their self-directed Medicaid community-based service budget at year end, contribute savings from employment, and accept limited contributions from others. Ultimately, LIFE Accounts would enable individuals to save money to reach long-term goals (for example, to purchase expensive equipment or attain higher education) and to obtain greater independence.

The administration looks forward to working with Congress to pass legislation authorizing me, as Secretary, to administer demonstrations to assist caregivers and children with serious emotional disturbances. Two demonstrations will provide respite services to caregivers of adults with disabilities and to children with severe disabilities. A third demonstration will offer home and community-based services for children currently residing in psychiatric facilities. The fourth demonstration will address shortages of community, direct-care workers by providing grants to States to identify best practices and develop models. Direct-care workers play an important role in providing care to individuals living with disabilities in the community and this demonstration should help address these workforce challenges.

MEDICAID AND SCHIP MODERNIZATION

Medicaid spending continues to rise each year. Total Medicaid spending for 2004 is projected to be $304 billion, nearly a tripling in spending over 10 years. Medicaid—not Medicare—is currently the largest government health program in the United States. Since Medicaid expenditures are a large and growing proportion of most state budgets, the Medicaid program is an area to which states turn to reduce costs including dropping optional Medicaid benefits or limiting optional groups from enrolling.

These concerns have fostered a dialogue between the Federal Government and the states regarding ways to improve and modernize Medicaid and SCHIP. Building on this dialogue, the administration will continue to work with Congress and other stakeholders to seek new ways to strengthen and improve the Medicaid and SCHIP programs.

In addition to structural reform, improving the fiscal integrity of the Medicaid program will continue to be a priority for the administration and HHS. Among these efforts, the administration proposes capping the reimbursement level to individual state and local government providers to no more than the cost of providing services to Medicaid recipients and restricts the use of certain types of intergovernmental transfers. The proposal would deem as "unallowable" certain Medicaid expenditures that result in Federal Medicaid and disproportionate share hospital (DSH) payments returned by a government provider to the state. The proposal would not affect legitimate intergovernmental transfers that are used to help raise funds for the state share of Medicaid costs. Rather, this proposal would only apply to intergovernmental transfers that are used to recycle Medicaid payments through government providers.

OTHER MEDICAID LEGISLATION

Extension of the Qualified Individual (QI) Program

The administration is committed to helping low-income seniors afford not only prescription drugs, but also health coverage through Medicare. Under current law, as authorized by MMA, Medicaid programs will pay Medicare Part B Premiums for qualifying individuals (QIs) through September 30, 2004. QIs are defined as Medicare beneficiaries with incomes of 120 percent to 135 percent of the Federal Poverty Level and minimal assets. The HHS budget would continue this premium assistance for one additional year.

Extension of Transitional Medical Assistance

As families make the transition from welfare to work, health coverage is an important component to ensure their success in contributing to, and remaining in, the work place. Transitional medical assistance (TMA) was created to provide health coverage for former welfare recipients after they entered the workforce. TMA extends up to one year of health coverage to families who lose eligibility for Medicaid due to earnings from employment. This provision will expire March 31, 2004. The administration proposes a 5-year extension of TMA with statutory modifications to simplify administration of the program for states. States would have the option to eliminate TMA reporting requirements; provide twelve months of continuous eligibility; and to request a waiver from providing the mandatory TMA program in their Medicaid program if their eligibility income level for families is set at 185 percent of the Federal Poverty Level or higher.

PARTNERSHIP FOR LONG-TERM CARE

The budget request, Mr. Chairman, includes a proposal to eliminate the legislative prohibition on developing more partnership programs for long-term care (LTC). The partnership for LTC was formulated to explore alternatives to current LTC financing by blending public and private insurance. Four states currently have these partnerships in which private insurance is used to cover the initial cost of LTC. Consumers who purchase partnership approved insurance policies can become eligible for Medicaid services after their private insurance is utilized, without divesting all their assets as is typically required to meet Medicaid eligibility criteria.

REFUGEE EXEMPTION EXTENSION

Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date, are not eligible for SSI until they have obtained citizenship. Refugees and asylees are currently exempted from this ban on SSI for the first 7 years they reside in the United States. To ensure refugees and asylees have ample time to complete the citizenship process, the President's budget proposes extending the current 7-year exemption to 8 years.

SPECIAL ENROLLMENT PERIOD IN THE GROUP MARKET FOR MEDICAID/SCHIP ELIGIBLE

This legislative proposal would make it easier for Medicaid and SCHIP beneficiaries to enroll in private health insurance by making eligibility for Medicaid and SCHIP a trigger for private health insurance enrollment outside of the plan's open season. This proposal will help states implement premium assistance programs in Medicaid and SCHIP.

MARRIAGE AND HEALTHY FAMILY DEVELOPMENT

This year the President is proposing a new marriage and healthy family development initiative. This Initiative is supported by funding increases in this Depart-

ment's fiscal year 2005 budget, encompasses a variety of new and existing programs, and impacts both mandatory and discretionary programs.

I am very grateful to the Finance Committee for acting to advance Temporary Assistance to Needy Families (TANF) reauthorization last fall, and I look forward to working together as the bill is considered on the Senate Floor in weeks ahead. Building on the considerable success of welfare reform in this great Nation, the President's fiscal year 2005 budget maintains the framework of the administration's welfare authorization proposal. We are committed to working with the Congress in the coming months to ensure the legislation moves quickly and is consistent with the President's budget. The President's proposal includes 5 years of funding for the TANF Block Grant to States and Tribes; Matching Grants to Territories; and Tribal Work Program. A new feature, intended to support the President's Marriage and Healthy Family Development Initiative, is a proposal for increased funding for two key provisions in our welfare reform package.

A cornerstone of the President's commitment to strengthen and empower America's families through welfare reform provides targeted resources to family formation and healthy marriage strategies. Statistics tell us that children from two parent families are less likely to end up in poverty, drop out of school, become addicted to drugs, have a child out of wedlock, suffer abuse or become a violent criminal and end up in prison. Building and preserving families are not always possible. But it should always be our goal.

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

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

As the committee may remember, President Bush announced in his State of the Union address a new initiative to educate teens and parents about the health risks associated with early sexual activity and to provide the tools needed to help teens make responsible choices. To do this, the President proposes to double funding for abstinence education activities for a total of $273 million, including a request of $186 million, an increase of $112 million, for grants to develop and implement abstinence educations programs for adolescents aged 12 through 18 in communities across the country; the reauthorization of state abstinence education grants for 5 years at $50 million per year as part of the welfare reform reauthorization; another $26 million for abstinence activities within the Adolescent Family Life program; and a new public awareness campaign to help parents communicate with their children about the health risks associated with early sexual activity.

In addition, the budget provides for significant increases to two State child abuse programs reauthorized this past year as part of the Keeping Children and Families Safe Act of 2003. The increase for the Child Abuse Prevention and Treatment State Grants will enable State child protective service systems to shorten the time to the delivery of post-investigative services from 48 to 30 days. The Community-Based Child Abuse Prevention program will increase the availability of prevention services to an additional 55,000 children and their families.

CHILD WELFARE

The administration is proposing a nearly $5 billion budget for Foster Care. These funds will be used to support the President's child welfare program option, which provides states more flexibility in both the population served and allowable activities. The funds will be used to provide payments for maintenance and administrative costs for more than 230,000 children in foster care each month, as well as payments for training and child welfare data systems. The HHS budget request reflects savings associated with a legislative proposal to clarify the definition of "home of

removal" in the foster care program in response to a court decision. The President's fiscal year 2005 budget also requests $140 million for the Independent Living Program and $60 million for the Independent Living Education and Training Vouchers program. Additionally, to support the administration's commitment to helping families in crisis and to protecting children from abuse and neglect, the President's fiscal year 2005 budget requests $505 million, full funding, of the Promoting Safe and Stable Families program.

CHILD SUPPORT ENFORCEMENT

The President's fiscal year 2005 budget, building on the high level of success achieved by the Child Support Enforcement Program, focuses on critical improvements in the arena of medical child support. Legislation will be proposed to enhance and improve State's efforts to collect medical support on behalf of children. These efforts include providing Child Support agencies with notifications of lost coverage (COBRA notices) so they can assist families in providing continuous health care coverage. Additionally, legislation would require states to consider both parents' access to health care coverage when establishing child support orders, with the option of enforcing medical support orders against both custodial and noncustodial parents. By assuring that IV–D agencies receive notice of a child's loss of health insurance coverage, and by seeking health insurance from either parent, more children will have access to continuous health coverage, which will result in healthier children and families.

These proposals build on the policies in the fiscal year 2004 budget that increase resources for the Access and Visitation Program to support and facilitate non-custodial parents' access to visitation of their children, and various proposals to enhance and expand the existing automated enforcement infrastructure at the Federal and State level. When combined with the opportunities to increase child support outlined in the President's fiscal year 2003 budget, such as expanded passport denial, the offset of certain Social Security benefits, and the optional pass through of child support to families on TANF, these proposals offer an impressive $8.1 billion in increased child support payments to families over 10 years.

COMPASSION AND FAITH BASED AGENDA

Compassion Capital Fund

The fiscal year 2005 budget requests $100 million for the Compassion Capital Fund, which creates public/private partnerships that support charitable organizations in expanding or emulating model social service programs.

Samaritan Initiative

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

DOMESTIC AND GLOBAL HEALTH IMPROVEMENTS

I would like to take a moment to share with the committee a few other priorities that strengthen our efforts for a healthier U.S. Building on the accomplishment of the 5-year doubling of the National Institutes of Health (NIH) budget, this year's budget proposal includes $28.6 billion for NIH. These funds will continue to support the long-term stability of the biomedical research enterprise and ensure continued productivity in all areas of research at NIH. To bring medical research and advances to those who need it, $1.8 billion of the HHS budget proposal provides health care services to 15 million individuals through the Health Center program and an increase for the National Health Service Corps to initiate recruitment of nurses and physicians.

The President's budget proposal for fiscal year 2005 also strives to meet the needs of our vulnerable populations. To protect our children from preventable illness, the budget proposes improvements to the Vaccines for Children (VFC) program to increase access to needed vaccines for underinsured children. In an effort to ensure we have enough vaccines when they are needed, the HHS budget request calls for a 6-month stockpile of all regularly recommended vaccines for children, as well as for a stockpile of influenza vaccine for next winter. In addition to our Nation's chil-

dren, we must not forget those struggling yet who are ready to help themselves out of the cycle of addiction and dependency. For fiscal year 2005, the President proposes to double the Access to Recovery State Voucher program, for a total of $200 million, to provide vouchers to approximately 100,000 individuals seeking substance abuse treatment services.

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

MANAGEMENT IMPROVEMENTS

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

IMPROVING THE HEALTH, SAFETY, AND WELL-BEING OF OUR NATION

Mr. Chairman and members of the committee, the budget I bring before you contains many different elements of a single proposal. The common thread running through these policies is the desire to improve the lives of the American people. Our fiscal year 2005 HHS budget proposal builds upon our past successes to improve the Nation's health; to focus on improved health outcomes for those most in need; to promote the economic and social well-being of children, youth, families, and communities; and to protect us against biologic and other threats through preparedness at both the domestic and global levels. It is with the single, simple goal of ensuring a safe and healthy America that I have presented the President's fiscal year 2005 budget today. I know this is a goal we all share, and with your support, we at the Department of Health and Human Services are committed to achieving it.

Secretary THOMPSON. Before I finish up, I just would like to answer, Congressman Spratt—I know the Governor of Michigan said that that was turned down. I don't know where she got her information. It has not been turned down. We are reviewing it, and we have given tasks and approval so far. So I don't know where the Governor made the announcement. It was picked up by the Wall Street Journal, but it was absolutely and completely erroneous.

Chairman NUSSLE. Mr. Spratt.

Mr. SPRATT. Do you expect to give approval to this and to other similar plans so that States will be allowed to form pools, purchasing pools?

Secretary THOMPSON. We are seriously looking at that, and our preliminary indications are that we will be.

Mr. SPRATT. Thank you, sir.

Chairman NUSSLE. Mr. Secretary, welcome, and thank you so much for your testimony. I would like to maybe go away from where I even said I was going to go and jump into—because of time, maybe the last questions first, and that is health costs.

When we deal with the budget that has been presented, we are dealing with the bill that is being presented, not what is under-

lying the bill, what is driving the costs. We are just getting presented the bill here; write the check. And part of the challenge that we have got and part of the frustration that we have with what happened from CMS and from the actuaries on the different amounts that could be at least projected to be for the costs of the Medicare bill is that we know that while they are wrong, we are going to stick with CBO. CBO says that it is $400 billion. There are going to be a number of estimates. Certainly they took into consideration the estimates or the projections of a number of different sources in coming to their conclusion, including CMS. So we are going to stick with the CBO numbers. Those are the best numbers that we have.

Having said that, though, I think what CMS is saying through its actuaries, certainly what you have counseled in the past and what many other quarters are suggesting, is that unless we deal with the cost drivers in health care, who knows what the price may be? It could be 534. It could be 834. It could be 334. Who knows what the price is if we don't start dealing with the driving costs? And this is one of the huge unpredictable portions of our mandatory spending accounts which are currently completely out of control.

Chairman Greenspan was here yesterday counseling us that we have got to get into the mandatory side of the ledger and to do a much better job of dealing with this. And certainly as you look at the mandatory side of the budget ledger, health care cost drivers are one of the most unpredictable volatile areas.

Would you please touch on your advice for how we move forward, what you see some of the cost drivers to be and how we can approach each one? And that is my only—that is a huge question. I realize we could do an entire hearing just on that subject, but if you could touch—and we should; you are right, Mr. Gutknecht. If you would touch on that to begin with, that is how I would like to use this time.

Secretary THOMPSON. Thank you very much, Congressman. I appreciate the open-ended question and giving me the opportunity to respond to something that I think we should. But first let me quickly tell you about why our actuaries thought it was going to be more costly for Medicare.

First off, our actuaries believe there is going to be a much increased participation for low-income Americans, and that is going to consist of $47 billion because of the subsidies; those under 100 percent of poverty, 93 percent of the cost of their drugs are going to be paid by the Federal Government. So there will be an increased participation of $47 billion.

The second big one is $32 billion, and that is where our actuaries believe that 94 percent of those individuals that are eligible for Part D will participate. CBO believes only 87 percent, because they said only 91 percent of the people participated in Part B; and if they don't participate in Part B, why would they participate in part D? And then the other increases are basically because of the woodworking effect at the State level, there will be more individuals coming into the program based upon our actuarial assumptions versus CBO.

But you have to base your figures on CBO. They are still at 395. We don't know if it is 94 percent participation or 87 percent participation, so nobody knows for sure. These are assumptions by your CBO and assumptions by our actuary, but that is the difference basically in the figures.

The second thing, how do we do this, how do we drive down costs? We drive down costs by addressing where the costs are. One hundred twenty-five million Americans right now suffer from one or more chronic illnesses, and 70 to 75 percent of the dollars go for chronic illnesses. Most of those are for individuals that have more than one chronic illness, and it is a very small percentage when you look at the total universe of those individuals that are using the bulk of the dollars. So how do we address it? Of that figure, $155 billion goes for tobacco related illnesses, and last year 442,000 thousand Americans died. If we are going to do something about expenses in health care, we have to address tobacco-related illness.

The second one is diabetes, $135 billion. We have just gone up from 16 million Americans to 18 million Americans right now that have Type 2 diabetes. About one-third of those don't even know it, and that is $135 billion, and it is a fast-growing epidemic, especially with minorities. And we can address diabetes very simply. NIH had a very exhaustive study. It was going to last 5 years. We quit after 2½ years because it was so complete, that if you lose 10–15 pounds and you walk 30 minutes a day, you can reduce the incidence of diabetes by 60 percent. And considering the fact that there are 16 million more Americans that are prediabetic, that will double to $270 billion over 135 unless we start addressing diet and exercise.

The third one, and the fastest growing one of all of them, is obesity and overweight. We spend $117 billion a year and over 332,000 Americans died from some obesity-related disease last year, mainly heart attacks, strokes, or hypertension. And what we have to do in America is we have to start changing our habits. And if we do that, we can address the three biggest causes of increasing health care dollars: tobacco-related illnesses and obesity, which has one-third of the cancer directed to it, and diabetes. These causes are where you are going to get it.

And as William Sutton said when asked why he robbed banks? He said, "that is where the money is."

That is where the cost drivers are, and that is what we have to address. We can do that by having a very aggressive program. Medicare was the first time that we have ever addressed this particular thing by putting in a baseline, borderline fiscal examination for all those coming into Medicare. And then we are going to start managing diseases. Ninety-two percent of the costs of Medicare right now go into waiting for people to get sick before we start treating them, and only 8 percent of the current Medicare goes into preventative illness. Under the new Medicare law with the baseline physical, we are finally going to start addressing people when they get sick, and start treating those sicknesses before they become so serious that it costs us millions of dollars to treat.

That is what we have to do as a country, Mr. Chairman, if we are really going to start controlling health care dollars. That is where the big drivers are.

Chairman NUSSLE. Thank you very much. Mr. Spratt.

Mr. SPRATT. Mr. Chairman, I don't want to beat a dead horse, but if I could just go back to the questions about the State plan. As I understand it, it was not just Michigan, but also Vermont; and is there an issue here about whether or not States will be allowed to pool their efforts and bargain collectively as opposed to allowing it to be done State by State?

Secretary THOMPSON. It has never happened before. They have applied for a waiver to do so, Congressman Spratt. We are looking at that and reviewing that. A final decision has not been made, but the preliminary finding is that we would accept it.

Mr. SPRATT. Can you give us an idea of what the criteria will be? I have a State in particular that is considering signing such a contract.

Secretary THOMPSON. The criteria is, is basically to make sure that the States are going to willingly and voluntarily go into the program. That has been basically the criteria.

Mr. SPRATT. If this is done, are you concerned it may raise a question, an uncomfortable question. The VA negotiates or sets prices, the States negotiate and set prices. Why can't HHS or why can't CMS, for 40 million beneficiaries?

Secretary THOMPSON. Let me tell you the rationale, not necessarily that I agree with, but I am going to tell you what the rationale is, Congressman Spratt.

Veterans hospitals negotiate and purchase drugs because they are the end users. They use the purchase of their drugs in the hospitals where they treat the patients. It goes to them. HHS does not purchase the drug and give it to the patients. It goes through an intermediary. It goes through a clinic or a doctor or a hospital, and under the new Medicare Modernization Act there is going to be PBMs or PPOs or HMOs that are going to be negotiating directly with pharmaceutical companies to drive down the prices.

The majority of the Members of the Congress felt that it would be much better to have those individuals negotiating the prices. They could do a much better job than the bureaucrats in HHS, or me as Secretary. That is the argument.

Mr. SPRATT. Here is the anomaly in Medicare. We set prices for physicians.

Secretary THOMPSON. We do.

Mr. SPRATT. We set prices for hospitals. But here is a whole segment of health care that is increasing faster than any other, and we have said, no, it is off limits, we will not negotiate, we will not set prices, we will let them go up pretty much as the providers determine. You have a problem with that, obviously. You were giving me the rationale. You didn't call it rational. You called it the rationale.

Secretary THOMPSON. I called it the rationale, Congressman Spratt.

Mr. SPRATT. Let me ask you another question about the President's proposal for passing this year some health care tax credits. In his inaugural—excuse me—in his State of the Union he told us that his budget would be coming shortly, and when it came there would be $65 billion for health care tax credits to help mainly those who don't have coverage now with a tax credit which would be re-

fundable. When we got the budget, we found out that, yes, indeed there was a proposal like that, but there was also an asterisk attached to it, and when you read the footnote and got the whole proposition in its full and proper context, the administration is saying, "but it has to be fully offset." And you know and I know in a budget this tight, coming up with $65 billion in offsets is a Herculean if not impossible task.

I asked Mr. Bolten—since the President's budget indicated that the executive branch would come over and work with us in identifying those offsets so that these health care tax credits could be passed—what he had in mind to start the bidding, what were they proposing to put on the table. And what he said was, we are going to take a good portion out of it, half of it as I recall, out of Medicaid. I suggested to him I was borrowing from one poor person to help another poor person. It was a net sum, zero sum game.

Could you tell us what kind of Medicaid cuts are in store or would be proposed in order to offset this health care tax credit proposition?

Secretary THOMPSON. You are setting me up, Congressman Spratt, because I was not privy to that. I don't know where Josh Bolten was going to get $35 billion out of Medicaid. I would have to recess the hearing to find out where he is going to get it. I don't know what he is talking about.

Mr. SPRATT. Could you give us an answer for the record, then?

Secretary THOMPSON. I absolutely could. There are ways to find offsets. I would be more than happy to work with you. But under Medicaid, the IGTs are an area that there is abuse, Congressman Spratt, that I would like to discuss in greater detail with you and other members of this committee.

Mr. SPRATT. Are you referring to disproportionate share plans?

Secretary THOMPSON. No, I am talking about intergovernmental transfers.

Mr. SPRATT. But not in the form of DSH or in the form of upper payment limits?

Secretary THOMPSON. No. I am talking about the way that we reimburse under the formulas.

Let me give you an example. I will give you a couple States' examples. State A made quarterly payments being electronically transferred them to the nursing home bank account. The State then immediately withdrew the amount of the payment from the provider's account, less a $2,500 participation fee. The approximate amount of Federal Medicaid payment returned to the State for the general treasury or to knock down more Federal dollars was $191 million. The law says that the intergovernmental transfers are legal if, in fact, the payment stays with the provider. In this case, $191 million stayed with the provider. It went back to the State to be used for something else or to knock down further Federal dollars. It is a big loophole. It is something I would like to discuss.

Mr. SPRATT. Let me ask you this before you go on to that. Is this a policy you have assumed and therefore put in your baseline as savings that is already taken?

Secretary THOMPSON. No. No. It is not taken. It is something that I inherited, and I am——

Mr. SPRATT. But does your baseline for cost assume that these changes will be made and therefore HHS will achieve some savings already assumed in the budget?

Secretary THOMPSON. It is not in the baseline, Congressman Spratt.

Mr. SPRATT. It is not in the baseline. OK.

Secretary THOMPSON. Can I go into one more State?

Mr. SPRATT. Yes, sir. Absolutely. Excuse me for interrupting you.

Secretary THOMPSON. No, that is quite all right. You can interrupt me anytime, Congressman. You are a perfect gentleman, and I mean that.

Mr. SPRATT. I appreciate it, sir.

Secretary THOMPSON. State B makes——

Mr. SPRATT. As a South Carolinian, that goes straight to my heart, sir.

Secretary THOMPSON. Your southern charm goes to mine.

State B makes supplemental payments to a county-owned nursing facility. Upon receipt of the payments, the nursing facilities are required to return 99 percent of the payment.

Mr. SPRATT. Let me just leave you—these other folks here have got questions to ask, and they are going to be as pertinent as mine, but my State is one of the States right now dealing with deferrals in the Medicaid program, where they have been sending you bills that have been approved for years at CMS and HCFA that are now being questioned; some of the intergovernmental transfers you were just talking about, DSH, upper payment limits, the administrative costs, stuff like that.

And we had a conference in Charleston just a week ago, and the folks there came away with the impression that HHS was making Medicaid so onerous and so rigorous and so complicated, so hard to deal with, that they would soon be pleading for a block grant with a discounted level of funding; that it would be better than this complicated, onerous program in putting up with all these regulations that they have changed over time.

Is that the underlying strategy?

Secretary THOMPSON. Absolutely not, Congressman Spratt. And let me quickly explain. Intergovernmental transfers are legal if in fact the State gets the payment from a provider, from a hospital, doctors, county institutions, whatever; but the payment has got to go back. The Medicaid law says that 50 percent approximately—let's just use a figure. Fifty percent of the money comes from the Federal Government, 50 percent comes from the State. Using the intergovernmental transfers, what the States are doing, they are taking the payments, asking for a tax or a provider reimbursement from the local units of government, taking that money and getting reimbursed from the Federal Government, and then using that money for other purposes, either general purposes—not the purpose for what Medicaid is set up.

What I am trying to say and what we are trying to do with our auditors is we are trying to say we want to help you, we want to make sure that the intergovernmental transfer payments in South Carolina are legal. Now, if we really want to be serious about it—and I am talking now as the Secretary of Health and Human Serv-

ices—there is about 5 percent of the total Medicaid program that is somewhat suspicious, and that figures out to about $9 billion.

Now, some States take advantage of it. Other States don't. Some of the smarter States are ones that have had individuals out there saying, you cannot cheat but you can get some more money from the Federal Government doing it this way. And other States haven't done that.

If we want to be fair about it. Why don't we stop the intergovernmental transfers across the board, and take that money and put it into an increased payment for the Federal Government? That would be much easier. It would be much cleaner and much more honest, and all States would be treated equally.

Mr. SPRATT. Thank you for your testimony, Mr. Secretary.

Chairman NUSSLE. Mr. Gutknecht.

Mr. GUTKNECHT. Thank you, Mr. Chairman.

And welcome, Governor Thompson. As you know, I am a big fan of yours. I think a lot of the welfare reform——

Secretary THOMPSON. I always feel like that, that I have to hang on to my wallet.

Mr. GUTKNECHT. Yeah. Hang on to your wallet. But I really mean that. Welfare reform around this country happened largely because of you and your leadership when you were Governor of the badger State.

I am not here to badger you today, but there are some things I want to talk about because I am not certain that you have been well served in this inspired debate about health care, health care reform, Medicare reform and ultimately about prescription drugs, because I think there are people who technically work for you who have not served you well in terms of giving you good information.

Now, let me also start by saying I am not an economist and I do not play one here on the Budget Committee, but I have learned a lot about prescription drugs, and I think you will agree with me that there are really only two ways to control health care costs. One is by direct government control and the other is by trying to create some kind of market mechanisms to create a competitive marketplace.

Let me give you an example, and I want to show a couple of charts. I think we have got them. If we can bring those up. The first one is a chart—and these are not my numbers. These were done at the Boston University in a study they released about a year ago.

And let's just look at 2002. For every dollar that we pay for name-brand prescription drugs in the United States, the Swiss pay 63 cents. The folks in Great Britain pay 62 cents. Canada 60 cents, and on down.

You know, it strikes me that if the people at the Boston University know that and if I know that, it just seems to me that people at the FDA should know that. And I am not certain that they have done a great job of sharing that information with you.

And let me give you a more specific example, and you have had an awful lot of things thrust upon you as Secretary of Health and Human Services, not the least of which is when we had anthrax here in these buildings. And at that time you went out and made a purchase from a German company called Bayer. At that time

they wanted something I believe like—and the numbers may not be exact, but it worked out to about $3 per capsule for CIPRO. You negotiated them down to about 80 cents. Were you aware at the time—or did anybody at the FDA tell you that that drug was available through the VA for 19 cents per capsule? That is embarrassing to me, that the FDA doesn't know that and doesn't share that information with you.

These are things that I think are important when we look at the overall cost of health care; that if I can learn that with a staff of one or two people, it strikes me that the FDA, with staffs of hundreds of people, ought to be able to share that information with the Secretary of Health and Human Services.

I want to show another chart, and this was something that we did. We were in Munich, Germany—and I am sorry this is a little hard for people to read, but I will go right to the bottom line. On our way home we bought 10 of the most commonly prescribed drugs in the United States, and we bought them at the Munich airport pharmacy. And those of us who travel to any extent know that if you buy—if you want to buy anything, you probably don't go and shop at the airport. Generally the airport has the highest prices. So I don't know what the prices were downtown, but this was at the Munich airport pharmacy. Those are the 10 most commonly prescribed drugs as far as we know in the United States, and the total is $1,039.65. We came back here to the States—I am sorry, the price in Munich was $373 and change. We came back to the United States and we priced those same drugs in drugstores here in Washington, DC, same dosage, same everything. They were $1,039.65.

You know, again, I understand you have some openings on this board that somehow was in the bill. I would volunteer to serve on that board to do a little research on this, but it just seems to me—and you don't necessarily have to respond here—but at some point as the Secretary of Health and Human Services, you have got to demand that people who work for the FDA, and technically work for you, help you get that kind of information, because it seems to me if we are going to be offering this huge new entitlement—and it is massive, and frankly I don't think it stops at $535 billion. My own view is and the Congressional Budget Office tells us that over the next 10 years seniors will spend $1.8 trillion on prescription drugs, and that number is going to grow. And so this is going to be an enormously expensive thing, and I do say publicly I don't think you have been well served by the folks who work under you.

And, with that, if you want to respond, you are more than welcome to, but I wanted that on the record.

Secretary THOMPSON. Well, thank you very much, Congressman Gutknecht, and as you know you have been a friend of mine for a long time, but let me go through several things.

First off, in regards to the CIPRO that I negotiated with Bayer—and we also included in it 69 cents, by the way. We also are paying for the management fee for managing the inventory, which is not something the veterans do. That is point No. 1.

No. 2, we have set up a commission according to a provision in the bill, and in regards to re-importation, we have got to give a report back, back to every Member of the Congress by December 1,

this year. We are going to absolutely take advantage of your knowledge on the subject, I don't know as a member of the committee, but certainly as a witness and as a resource person. And that is No. 2. And we will have that commission report in for all Members of the Congress by December 1, this year.

No. 3, the law right now on re-importation, as you know, requires me to certify that the drugs coming into America are safe. We had a target enforcement action twice this past year and the first target was on July 29th to the 31st and August 5th to the 7th. The second one was in November of this year, and 87 percent, approximately, of the drugs that came in were somehow defective. And based upon that information, there is no way that I can certify that all drugs coming into America are safe.

Now, some of those drugs were packaging problems. Some of them came in from different countries that said they were coming from Canada. Some of those drugs were drugs that FDA had not approved and were being sold in this country. Those are things that we have to be concerned about. If re-importation is going to go ahead, I think the best way to do it is to have this commission complete the study and get the necessary resources to FDA so that we can do it properly and safely.

Mr. GUTKNECHT. But in truth, most of the reason for that 87 percent was some of the language on the capsule, or on the packages, were in foreign languages. They were still the same drugs.

Secretary THOMPSON. Some were. There were some that were not.

Chairman NUSSLE. The gentleman's time has expired.

Mr. Moran.

Mr. MORAN. I thank you very much, Mr. Chairman, and you do have fans on both sides of the aisle, certainly in terms of your effectiveness as Governor of Wisconsin, Secretary Thompson. I guess that is why we aren't hesitant to push you on some of the things that we feel most important—that we feel are most important to our constituents.

Obviously on Medicare, you are going to hear a lot about the inability to negotiate for lower prices. Mr. Gutknecht did a nice job of underscoring that. Mr. Moore has a bill that many of us have cosponsored that is bipartisan, so I am going to defer to him to push that, and I trust others are going to raise the issue of the American taxpayer paying for these ads promoting a bill that is as controversial as this one is, and that would have failed in the House had it not been held open for 3 hours.

But I am going to go on to another issue, because I was concerned that in your testimony, Mr. Secretary, you didn't mention another very serious national problem, and that is the problem of the uninsured. During your watch, the number of uninsured has increased by 2.4 million people. It is now close to 44 million as you know, and during the course of a year, about 75 million people are actually without health insurance at some point during that year. About 4 million people have lost their job-based health insurance over the past 2 years.

And so we would like to know what is your vision, what is the administration's plan for addressing that? We can't be paying for it out of local property taxes, when a hospital has to take in indi-

gent people that are uninsured through the emergency room, and you know how ineffective and inappropriate manner of health care that is.

There have been three proposals that have been made by the administration. One is the tax credits. Another is the associated health plans, and then you have got this deductible proposal that——

Secretary THOMPSON. And health savings accounts.

Mr. MORAN. The health savings accounts. Now, in terms of the tax credit, it said in your mid-session review from last year that this is when you lowered the cost of the proposal. It said the proposed tax credit is now assumed to be implemented more slowly and thus to cause less reduction in employer-sponsored health insurance. But what struck us is that that is the clear implication that the proposal does, in fact, lead to a drop in employer-sponsored health insurance, which is only rational.

Now, the second proposal you have, the associated health plans, our estimate that we got from the most extensive analysis—this was from the MIT guy—said it is going to save—it is going to provide health insurance for about 330,000 people, which is good. I am a cosponsor of that legislation actually, but it is a drop in the bucket in terms of addressing the 44 million people who are uninsured.

And then in terms of those health savings accounts, the fact is that the vast majority of people who are uninsured, in fact 90 percent of the uninsured, were either in the 15 percent tax bracket or had no tax liability. So I think it is a stretch to suggest that these health savings accounts are going to help anybody but those who are in relatively high brackets, who likely have the least need for help in terms of paying for health insurance. So I would like to give you an opportunity to address how you realistically think we can reduce the number of uninsured.

Secretary THOMPSON. Thank you very much, Congressman Moran. And as you know, I temporarily live in your district, so I appreciate——

Mr. MORAN. That is one of the reasons I am being so kind.

Secretary THOMPSON. I assume that. I have a tremendous amount of influence in several blocks in your——

Mr. MORAN. Yes, I know. You live in Cameron Station. I am very conscious of that, and I have ticked off too many constituents that have been before me on this witness panel, so I am going to try to be a little more——

Secretary THOMPSON. Congratulations on your engagement.

Mr. MORAN. Thank you, Mr. Secretary, but I still need you to answer the question.

Secretary THOMPSON. Well, let me answer your question in several ways, because you have made several targeted accusations that I want to rebut quickly.

No. 1, in regard to the Medicare ad, I am under the legal responsibility under the act to promote and get out as much information as possible. You and I differ as to the contents of the ads, but I had the ad scrubbed with several different groups, and all of those individuals independently from my sources in the department. I personally went out and did this, and they all indicated to me that they felt it was very nonpolitical.

Secondly, in regards to you saying that the uninsured increased under my watch and indicated maybe I had some responsibility for that, they have increased; but I also want you to know I have used the power of the Secretary to grant waivers in which 2.4 million Americans across this country, mostly low income and minorities, can now have health insurance under the waiver process that I have. And I have expanded benefits to 6.7 million other Americans. So I am using every bit of power I possibly get to give insurance to those individuals that need it, and we will continue to do so as long as I am Secretary.

The third, I didn't mention the uninsured in my remarks because I didn't have time. I would have loved to. There are several things that I would like to see happen. I think the President has laid out the tax credits, the association health plans, the health savings accounts. I would like to take those tax credits, Congressman Moran, and I would like to see some—bipartisan support to do this. I would like to have this put into a pool in which every State would be able to get their portion. Virginia would get their portion. Wisconsin would get their portion. Have the Governor and the State legislature set up the uninsured into a pool, set up an insurance or insurance commissioner to go then out and negotiate.

As you know, you have studied this, there is a good share of those individuals, the uninsured, who are very strong insurable risks, some of those individuals over $50,000 a year. One third of them are very healthy. One third of them are under the age of 29. So it would be a very good insurable risk. You would put those into a pool and then you would allow for bids, and then you would be able to cover a lot more individuals. This is one way to do it.

Health savings accounts is another way that—I know you disagree because you believe that it is only going to be a tax reduction for the rich. I think it is a way for—maybe there are ways to scrub it, but there are ways in which we can get more people to really purchase insurance.

You could also use the health savings accounts as another idea as to be able to allow for those individuals that purchase a health savings account to be able to have a high deductible and then be able to use some of the money for purchasing medical provisions under the tax credits, and there are many ways to do this.

And I would like to sit down with you and give you some ideas on how we might be able to come up with a bipartisan bill to expand insurance for the uninsured. I think we should do it. I think there is some way to do it.

There are other ways you can do it. You can take a look at the SCHIP program. There are $7.8 billion left in the SCHIP program. You could find ways in which we could use that money to develop a very good health insurance program, like we did in Wisconsin, called "Badger Care" to give those individuals coverage.

Mr. MORAN. Thank you, Mr. Secretary.

Chairman NUSSLE. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman and Mr. Secretary, it is good to see you again. And you have a very difficult job, and I think you have performed your duties very, very well.

I want to kind of pick up on this whole notion of insured and uninsured from maybe a different perspective. When we look at

health insurance in this country, that insurance is unique compared to other insurance. And by that I mean in many cases it is only available as a condition of employment. Somebody doesn't go to work for X company because they offer good property insurance, or at Y company because their car insurance is better than somebody else. But health insurance falls into that category as a result, rightly or wrongly, since the Second World War when all of this came about. It tends to be arm's-length, third-party pay and not an individual making those decisions. And I happen to think that as a result, in many people's minds, health insurance to them is prepaid insurance or prepaid health care. And I would just make the observation that there is a huge difference between prepaid health care, because that implies you are paying something at some time, but you are paying it in full, for the benefit to accrue when you want that, or prepaid insurance in a classic insurance case which you take care of the unexpected.

Now, with that in mind, the chairman in his opening remarks was talking about controlling health costs, and Mr. Gutknecht talked about finding some market mechanisms, albeit in different ways, but nevertheless with health costs. It seems to me that the concept of HSAs goes a long way to alleviating all of this, simply because you are empowering people to make their own decisions.

I happen to think that the HSAs within the Medicare bill is one of those significant policy changes that we had made, and I just wonder if you have any evidence, having noticed the marketplace out there since HSAs have gone into place the first of this year, if you are seeing a lot of activity in that area.

Secretary THOMPSON. We are seeing a lot of activity on all aspects of the Medicare Modernization Act, much more so than we ever thought possible. Health savings accounts is one of those, Doc, that is receiving a lot of things—a lot of inquiries coming in as to where they might be able to purchase this—into the Department.

Secondly, on the card we expected maybe 50–60 applications. We have 106. One has withdrawn, and one has merged. So we have 104 left; 55 across the country and regionally, and 46—48 are from those individuals that are in HMOs and want to be able to enroll their members. So there are a lot of inquiries, a lot of telephone calls coming in to our 1–800–Medicare line. Our Web page is just phenomenal, asking questions about the Medicare, and when is it going to be implemented and how soon they can start getting benefits.

So it is not only the health savings accounts. All aspects of the Medicare Modernization Act are receiving overwhelming kinds of inquiries at the present time.

Mr. HASTINGS. Well, I support it because of HSAs, obviously, but also because of the reimbursement formulas for rural areas. I come from a rural area, and I can tell you that my providers are very pleased with that. And I gather you are probably hearing the same thing.

Secretary THOMPSON. This was the best bill that rural areas in America could have ever hoped to get. Thanks to Congressman Nussle's leadership and Senator Grassley's leadership for a long time, your leadership, Congressman, and so many people that represent rural areas, this is an excellent bill for reimbursements. To

be able to reduce the wage disparities—which makes up the high percentage of the reimbursement in the market—from 72 cents down to 63 cents is a wonderful thing. To allow for increased payments for doctors in underserved areas and be able to increase the disproportionate shares by $6 billion. There is a total of $26 billion for rural areas and a total of $36 billion for States that are going to get reimbursed.

So I would compliment all of you who are a part of it, because none of us—I have been fighting for this as Governor of the State of Wisconsin for years. In fact, I brought a lawsuit against—as a Governor, because of the disparity of payments to the State of Wisconsin. We weren't quite as bad off as Iowa, but we were right up there, and this bill was exceptional for the States of Iowa, Wisconsin, Oregon, Washington, the Dakotas, and Nebraska, Montana, and Wyoming. And most rural States got a huge benefit.

Mr. HASTINGS. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Chairman NUSSLE. Ms. Hooley.

Ms. HOOLEY. Thank you, Mr. Chair.

Mr. Secretary, welcome. I have to peek around other people to see you.

I have a couple of very quick questions. One is, I am going to go back to prescription drugs. That is an issue that all of us have been talking about for a long time, the high cost of prescription drugs. They just seem to be going up exponentially each year. I think the increase is something like 14 percent this year.

And I just have a hard time understanding your opposition to negotiating prices. I mean, you negotiated with CIPRO. I know you negotiated getting more flu vaccine. I mean, everywhere that I know of in Federal Government, the VA negotiates, everywhere in government, we negotiate for automobiles, we negotiate for all kinds of equipment and office supplies. What is your objection to negotiating the price of prescription drugs?

Secretary THOMPSON. I will tell you the rationale again. The Veterans Department has the power to negotiate and give the drugs to individual patients in the veterans system, and we do not purchase drugs and give the drugs away. We set prices. We allow for the reimbursement formulas, but the actual payments go to the fiscal intermediaries, the contract carriers. And under the new Medicare Modernization Act, the new way to do it was to be set up by PBMs and PPOs and HMOs to do the negotiating. And the Congress in their wisdom thought that it would be better for those individuals to have the power rather than the Department.

Ms. HOOLEY. Another question just along those lines. Do you have any kind of a program, for example, where you have research done—independent research done on drugs that provide the same benefit? For example, if you have arthritis you can take Vioxx, you can take Celebrex, you can take ibuprofen, and there are probably a whole bunch of others.

Secretary THOMPSON. We have——

Ms. HOOLEY. Where you look at all the drugs that do the same thing for the disease or the condition, and that you have some comparison then as to side effects and to the costs, so that every doctor in their office will know that if a patient comes in and they say,

I have arthritis, that they can give them some choices at least, or know which drugs cost the least amount.

Secretary THOMPSON. We do, but not as complete as I would like or, I am sure, you would like, Congresswoman. But let me tell you what we are doing right now. We are setting up in CMS a Web page in which, when the card rolls out, we will have every card issuer and their prices on every drug and every formula that they have, and we will have the prices on every drug so that you will be able to look it up every single day. It will be updated on a weekly basis, and every cardholder will. And then we are going to give this information out. So if you are a senior citizen, you call up 1-800 Medicare with your list of prescriptions. You will call us and say, these are the prescriptions. And we will say, how far do you want to travel to your drugstore? And that information we will have online as well. And then we will be able to compare every card issuer, what they got in cost, and be able to tell your constituent, that senior, Mrs. Jones, what she will have to pay and what would be the best price, best deal for her.

On top of that, on the $600 credit for low-income seniors, Merck has just announced that they are going to give away all of their Merck drugs free of charge to that category of people above the $600. So those individuals with under 135 percent of poverty that are using America drugs will first get a $600 debit card and then they will get their Merck drugs free of charge.

I think that is going to certainly encourage other pharmaceutical companies to do the same thing. And what this is going to do, this transparent Web page is going to have a tremendous tendency to drive down prices not only for seniors, but for States, for individuals, and for companies, because they can look in and if they can see what the price is. They are going to be able to say, Why can't I get that price?

Let's take three stabs, Lipitor, Zocor and Mevcor, and right now Lipitor is the fastest and the largest selling drug in America.

And mevacor and Crestor. And we will have information on all three of those statins, plus the prices.

Now, Merck sells Zocor. For those under 135 percent of poverty, it will be given free of charge. You can't get any lower than that. And so I think it is going to have a tendency on Pfizer, who sells Lipitor, that they are going to have to be competitive; or mevacor, which is going to be sold by Astra Zeneca, and I am using that as an example of what it is going to do to drive down prices.

Chairman NUSSLE. Thank you.

Mr. Bonner.

Mr. BONNER. Thank you, Mr. Chairman.

Mr. Secretary, welcome. First of all, could you restate the number of waivers that you have issued during your tenure as Secretary?

Secretary THOMPSON. I have issued 3,600 State plan amendments and waivers since I have been there, more than all the 18 previous Secretaries combined.

Mr. BONNER. I would like to say thank you on behalf of one you issued for a young man from my district in Alabama, Nick Dupree. Nick's story is tragically familiar to a lot of Americans. He is a quadriplegic. He lives every breath on a ventilator. He graduated

from Spring Hill College, and because he reached the ripe of old of age 21, he was being forced into a nursing home until your office intervened.

So I know it is easy to fire shots at you. I would like to say thank you for what you did for Nick and 29 other people from my State.

Some of my friends on the other side seem to want to——

Secretary THOMPSON. We approved that waiver in one day.

Mr. BONNER. I know that. It was right after I met with you last year, and I want to say thank you.

Some of our friends on the other side seem to want to have it both ways. They want to blast those of us in the majority and the President for fiscal irresponsibility, and at the same time seem to offer billions upon billions of dollars of amendments that if they were in charge would spend even more money.

And so my question to you is, according to CBO, last year's Democratic alternative to the House-passed Medicare bill would have resulted in direct spending outlays of $1 trillion over 10 years. In your view, what do you believe would have been the implications to Medicare's financing over the long term if that alternative had in fact made it into law?

Secretary THOMPSON. Well, it is obvious it would have been more, because you are starting at a higher base. And when you add on to that base increased expenditures, you are going to have a much higher outlay than the bill that finally passed.

Mr. BONNER. That is all, Mr. Chairman.

Chairman NUSSLE. Thank you.

Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here. I want to delve a little bit further into some of the discussion that has already been prompted on the uninsured. As you know, it has been one of my lifelong passions in politics, and I was very encouraged to hear you talk about some of the ideas you have of where we could go from here to tackle that problem.

Unfortunately, I think a number of those aren't yet captured in the budget that is before us, but are really ideas that you are opening up an invitation for bipartisan discussion of where we go from here.

What I wanted to focus on a little are some serious discrepancies in the numbers of how many people are estimated to be impacted by the three major proposals that are contained in the President's budget to address the uninsured, those three proposals being, as Mr. Moran earlier outlined: the refundable tax credit at a price tag, I think, of $70.1 billion, the association health plans, and also specific tax deductions for catastrophic health insurance. You added in there the health savings accounts, but these are sort of the three that have been put forth by this President.

I know that you had a chance to testify not too long ago in front of the Ways and Means Committee in which, in that testimony, you gave an estimate that it was your hope that those three proposals, sort of taken together, could extend health insurance opportunities to perhaps half of those who are uninsured. I heard the figure reported, 20 million was the hope.

You are probably aware that a number of——

Secretary THOMPSON. If I said that—I don't believe I said that. But if I did, I misspoke, because it does not cover that many.

Ms. BALDWIN. OK. My understanding was that that was your testimony in front of the Ways and Means Committee, that these policies would cut the ranks of the uninsured in half, a reduction of roughly 20 million.

I would like to—would like a correction if indeed that wasn't your testimony.

What I wanted to bring forth was the information that a lot of us have looked at of late in evaluating these programs, a professor, as you heard, from MIT estimated that the refundable tax credit might extend health insurance to perhaps 1.9 million people who would be currently among the ranks of the uninsured.

A CBO study indicated that the association health plans might provide, modestly, 330,000-additional people health insurance.

And there was difficulty in even getting a number estimate on the third proposal.

But when you aggregate, you know, it is looking about 2.2 million, which is great. I would not want to criticize in any way that type of extension of health care. But I have to question the bang for the buck. And certainly there are other initiatives that could be put forward where we would be making a much bigger dent.

So if these three are the centerpiece proposals for addressing our incredibly desperate problem with 43.6 million uninsured individuals, that only counts, as you have heard, those that have been uninsured for a full year, probably 75 million who have been episodically uninsured throughout a year.

To have three proposals that may help 2.2 million of those 75 million at a cost of close to 100 billion, I want to know if your figures are different. And certainly if you want to elaborate any more on problems that would—on proposals that would get to a larger share of the uninsured, I would certainly love to hear those ideas.

Secretary THOMPSON. First, the tax credit proposal that the President has advanced, which I support, is supposed to cover a little over 4 million people. I do not know the exact number. I can look it up on the association health plans. We think it is higher than what your figures are.

But—and the tax deductible one, I don't know if you can quantify as to how many people that is going to help, but let's say it is somewhere between—let's say you are at 2.5 million and we are at 5 million. What I was saying in Ways and Means, there are ways and proposals that we could come up with that, could get a lot more, a higher percentage. And I said I would hope that some day we could get to one-half.

Ms. BALDWIN. Yeah. Just for clarification, I think Congressman Levin asked concerning the administration's plan and your response—somebody just gave me the transcript—was——

Mr. SHAYS [presiding]. You know, the gentlelady's time has run out, and I really want to make sure that others on your side get a chance to respond.

Secretary THOMPSON. I know your passion, Congresswoman Baldwin, for this. I would love to work with you to come up with ideas. I have some ideas, and I am sure that we can come up and

hopefully get together a bipartisan package that would help the uninsured.

I would much rather—instead of arguing about it, I would like to come up with policies which we could work on together to get it done.

Mr. SHAYS. We are going to go to Mr. Hensarling and then to Mr. Moore and then to Mr. Diaz-Balart and then to Ms. DeLauro.

Mr. HENSARLING. Thank you, Mr. Chairman.

Good morning, Mr. Secretary. I learned a lot from your presentation as far as some of the cost driver are concerned——

Secretary THOMPSON. Thank you.

Mr. HENSARLING. In the provision of health care through the Federal Government, I think you mentioned that 8 percent of the budget is presently spent on preventative care.

Secretary THOMPSON. Medicare.

Mr. HENSARLING. OK, on Medicare, preventative care.

In private insurance plans, quite often people are incented to—financially—to engage in good, healthy behaviors. Many private insurance programs obviously will lower your premium if you are a nonsmoker. My observation is that the world works off of incentives, what incentives do we presently have in the system for people to be nonsmokers, to have reasonable diets, to engage in reasonable exercise?

Secretary THOMPSON. We don't have much. We don't have much. And that is something that this Congress, and I applaud you for bringing up because we have to build in some incentives to encourage people to practice good behavior, whether it be a credit on your health insurance like, for example, if you are a good driver, you usually get a credit on your automobile insurance policy.

I have had the health insurance companies come in, and I talked to them about putting on a credit on their health insurance for practicing good behavior. So if you are physically fit, you are exercising, watching your diet, you get a credit on your health insurance. They liked the idea, but they said there are too many rules and regulations and laws that prevent them from doing it.

Now, that would be one thing right there that, if we wanted to strike a blow for freedom, give health insurance companies the opportunity to give health insurance policies with an incentive to practice good behavior, which is going to save the State and the Federal Government millions of dollars.

Mr. HENSARLING. I would also like to strike a blow for freedom, Mr. Secretary.

Secretary THOMPSON. Thank you.

Mr. HENSARLING. I appreciate your bringing it to my attention.

Speaking of regulations, I am under the impression that there are roughly 130,000 pages of regulations and forms in the Medicare program. I am also led to believe that the Federal Employee Health Benefit Plan, which many would argue delivers better health care at a less expensive price, has roughly 56 pages of regulations.

At what point does the regulatory burden become so large that we provide a disincentive for companies to come in, participate in Medicare, and create a more competitive marketplace? And to what extent is the regulatory burden a cost drivers in health care in America?

Secretary THOMPSON. I think they are tremendous. And what I am trying to do is, I am trying to change that. What we need to do, Congressman, is to start getting to a paperless system in America in the delivery of health care dollars.

Grocery stores are more technologically advanced than hospitals and clinics. And the regulations are required by laws that you pass and the Congress passes and are signed into law by the President.

We are trying to mitigate many of those rules and regulations and make it easier. Like the privacy law; we had to make many changes to that to make it meaningful.

But getting back, if you really want to get at this thing, you could probably talk about somewhere between 25 to 50 percent of cost if we could get to a paperless system. And so that you could have uniformity, I have requested the Institute of Medicine to come up with a uniform patient record. We don't even have a uniform patient record in America.

Second thing, we have hired—we have licensed what we call, from the pathologists, SNOMED, which is the vocabulary of all the illnesses in America, and we are going to give that out to anybody that wants it free of charge.

Third, we are going to get uniform standards put in place so that the hospitals and clinics in your district will know that they have these kinds of standards to meet so that they are going to purchase the kind of software and the kind of computers that are going to be able to be compatible.

And then you know my ultimate goal is to be able to get a chip developed so every one of us have a personalized chip with our health medicine information that can be downloaded, and you would then be able to have uniform patient records, uniform lexicon and uniform standards on a chip. You could drive down the cost and make this administration much easier.

Mr. HENSARLING. Thank you.

Mr. SHAYS. We are going to try to make sure we go down this list; and let me just tell you, we have Mr. Moore and then Mr. Diaz-Balart and then we are just going to go down the Democratic list, and I will say—and not ask questions, and you can see we have more than six and we have to finish up in 35 minutes, so——

Secretary THOMPSON. I will make my answers shorter too.

Mr. SHAYS. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

Mr. Secretary, welcome. I want to recount for the committee a conversation we had. In fact, the week of the vote on the Medicare bill, Mr. Secretary, you met with the Blue Dog coalition, had a discussion with that group, I think on Tuesday.

Later that week—and I believe, Mr. Secretary, it was the day before the vote—I got a call from you at my office and I am going to recount this as accurately as I can, as I remember.

You said, Congressman, can you be with us on this bill?

And I said, Mr. Secretary, I really have not made up my mind.

As you know, with any major piece of legislation, there is some good news and bad news; and the good news in this bill is catastrophic coverage and low-income coverage and the fact that there is reimbursement for physicians and hospitals, Medicare providers here. And I said, That is the good news.

In our discussion I think you said something like, "What is your concern?"

I said, "Mr. Secretary, there are 25 million veterans in this country and the Secretary of Veterans Affairs on behalf of those veterans has the authority under Federal law to negotiate lower prices, try to negotiate lower prices." I said, "I wish you had that authority."

As I recall, Mr. Secretary, your response was something like this. "If I had that authority, Congressman, I would gladly exercise it, but as you know, this bill prohibits that."

And I said, "Mr. Secretary, that is my concern about this bill and that is why I still haven't made up my mind."

In fact, I ended up voting against the bill, even though I was leaning to voting for it, because I think it failed to address the cost issue.

Part of our discussion, I said to you also was, "There are 40 million Medicare beneficiaries in this country, and right now each of those persons is a one-person buying group. And if we would lump 5 million, 20 million or 40 million people in a buying group, there should be some leverage there for you or somebody on behalf of those beneficiaries to negotiate lower prices, again just as the Secretary of Veterans Affairs does."

And I said, "Our seniors pay, I believe, among the highest prices in the world, and in effect, our seniors subsidize people in Canada and Mexico where there are price controls." And I will tell you, Mr. Secretary, I do not believe in price controls.

I want our pharmaceutical companies to make a profit and continue to develop the world—these wonderful drugs that provide quality of life and, in fact, keep people alive. On the other hand, I don't want them to make their profits just on the backs of American seniors.

So I introduced a bill with Jo Ann Emerson from Missouri. And this bill would specifically repeal the one section of the Medicare bill, H.R. 1, that was passed and give you specific authority to negotiate, on behalf of 40 million Medicare beneficiaries in this country, lower prices.

And my question to you is, if you had that authority, would you exercise it, No. 1?

No. 2, if the bill passes—and we have 125 bipartisan cosponsors right now—if this bill would pass, would you recommend to the President that he sign it, sir?

Secretary THOMPSON. First off, even if I had the power, I don't know whether or not it would be used very often, the reason being because, right now, we don't purchase the drugs. The Veterans Department does.

The PBMs are going to purchase the drugs, or the PPOs are going to purchase the drugs, and the HMOs are.

But if I had the power, of course, I would use it. I have never been reticent about using power. And so if I get the power, I would use it. But I am just telling you, I don't know whether or not it would be usable because of the way the system is set up.

Second thing, you are absolutely correct, seniors pay the highest amount of the drugs because nobody is negotiating for them. Under the new bill, under the new Medicare bill, they will be having peo-

ple negotiate with them and the transparency on the Web page is going to be very helpful. It was not only the Republican bills that had this non-negotiable language, it was the Democrat bills as well; and I just want to put that on the record.

Mr. MOORE. I appreciate that, but I want to say this. I think and I hope that all of us in this room and in Congress can get away from—this should not be about Republicans and Democrats. This should be about American seniors and the American people.

Secretary THOMPSON. I agree.

Mr. MOORE. I know you do, Mr. Secretary. I absolutely believe that you want the best for health care in this country. I really believe that.

Secretary THOMPSON. I am passionate about it.

Mr. MOORE. I know you are. I could tell in your opening statement that you are. I know that.

One more question. I will finish very quickly here.

Mr. SHAYS. The gentleman only has 22 seconds.

Mr. MOORE. I understand that, if I can finish, Mr. Chairman.

Mr. SHAYS. Well you have got to leave him time to answer.

Mr. MOORE. Well, then, I won't ask the question.

Mr. SHAYS. Let me just say I am just trying to accommodate eight members so they get chances as well. We will go to Mr. Diaz-Balart and then to Ms. DeLauro, and then we will go to Mr. Scott, to Mrs. Capps, to Mr. Emanuel, Mr. Davis, Ms. Majette, and so on.

Mr. MOORE. May I submit the question to him in writing?

Mr. SHAYS. Sure. Absolutely.

Mr. MOORE. Thank you.

Mr. DIAZ-BALART. Thank you, Mr. Chairman.

Mr. Secretary, the programs within the Department of Health and Human Services historically have been notorious for being burdened with waste and fraud, and abuse. And nobody has done more to fight waste, fraud, and abuse when you were Governor, and now, as you have; and I think everybody understands and applauds you for that, sir.

Can you discuss some of your successes in fighting waste, fraud, and abuse within your Department? And also some of your future plans to continue to fight what I know we all believe is a major problem.

Secretary THOMPSON. The IGT is one area that we are looking at right now. We have put in some new auditors that are going to be able to, we think, modernize our system completely. We have modernized our computer systems; that is badly needed because some of our software is 30 years old in the Medicare reimbursement system. Some of our software is older than the technicians that we have hired to maintain it. So we are doing some improvements there.

The third thing we are doing is, we are putting a lot of emphasis on getting delinquent child support collected, something that hadn't been done before. And we are increasing the amount of money each year we take on waste, fraud, and abuse. We just have made some huge cases and got some others pending, and the amount of money that we take in on waste, fraud, and abuse is going up each and every year.

Mr. DIAZ-BALART. Mr. Secretary—and just for an example, I am not picking on anybody. The NIH has received some, I think, well-deserved criticism. We all know that they do some essential things for the country, but they also have some egregious examples of waste. For example, a recent NIH grant funded research that observed—this true; I am not making this up—observed individuals watching pornography while drinking alcohol. When people found out about it, they all wanted to sign up.

That is $470,000 just on that issue alone, and it seems to me that people have to be held accountable for their actions. And, everywhere if the people are not held accountable, you do not get accountability.

Do you have any ideas, any steps that you are thinking of taking to hold people accountable for such examples of waste that are pretty obvious to—you know, do not pass the straight-face test.

Secretary THOMPSON. Yeah. I have asked Elias Zerhouni, who I think is one of the best NIH directors we have ever had in this country. He is having a rigorous review of this stuff.

I don't want to get involved in reviewing scientifically based things, because I am not a scientist. He is, and so he is much better and more capable, and he is responsible for the NIH. The same thing for Dr. Gerberding at CDC. They are responsible for making sure that the grants that are given are grants that are based upon good science, and they are doing that.

As far as NIH, they are taking a look at the ways that this story that was put in one of the California newspapers—they are having a huge review. In fact, Elias Zerhouni was up here and testified, I believe, in the Senate Appropriations Committee about the review process he has done. He has set up an independent investigation, and he has brought in some real outstanding national and international scientists to review what the allegations were and what is going on. And we will make all of that information available to you and to every Member of Congress.

Mr. DIAZ-BALART. Thank you, Mr. Secretary. I think all of us know that nobody has tried harder to make sure that the taxpayers' money reaches those that are really most needy.

Thank you, and we want to thank you for those efforts. Thank you, sir.

Secretary THOMPSON. Thank you very much, Congressman Diaz-Balart.

Mr. SHAYS. I thank the gentleman.

Ms. DeLauro, you have the floor.

Ms. DELAURO. Thank you very much, Mr. Chairman.

Mr. Secretary, welcome. I will get another chance to ask you some questions at Labor, HHS.

If you want the authority, we would like to give you the authority. Cipro is produced at Bayer which, as you know, is in the Third Congressional District of Connecticut; and we thank you for driving that cost down. I didn't know it was 19 cents from the VA.

But the authority can be had, and I believe that, in fact, you would use it.

Let me move to a different area which has to do with the prescription drug ads. I understand that late last night HHS submitted the material to the GAO answering questions about the po-

tential misuse of government funds by the executive branch for the publicity or propaganda effort around the Medicare law.

Can you get us those responses so that we can make it part of this record, and can you get us a list of where the ads were run?

Secretary THOMPSON. Sure.

[Secretary Thompson's response was sent to Representative DeLauro's office 10/14/2004:]

Ms. DELAURO. Fine. Thank you.

And we also would like, for the record, Mr. Chairman, the letters that many of us on the committee sent to the Secretary and also to the IG, to make those part of the record.

Mr. SHAYS. Without objection, they will be part of the record.

[The information referred to follows:]

LETTERS SUBMITTED FOR THE RECORD BY HON. ROSA L. DELAURO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

HON. TOMMY THOMPSON, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES.
February 4, 2004.

DEAR SECRETARY THOMPSON: We are writing to express our outrage at the administration's announcement of a massive taxpayer-funded advertising campaign to promote its Medicare bill. Just 1 day after presenting a budget that eliminates and cuts critical programs, America's working families are being asked to foot the bill for the administration's election year advertising.

Yesterday, the White House announced that it will use $9.5 million from your Department for a television ad campaign to "rebut criticism of the new Medicare law". In addition, $3.1 million will be used for newspaper, radio and internet ads in both English and Spanish. This new ad campaign raises serious questions about the administration using taxpayer funds for political purposes. Accordingly, we would like you to provide the following information:

The rationale for spending taxpayers' funds on this ad campaign. If this is an effort to educate the public about the prescription drug legislation, why does it advocate particular points of view that are clearly controversial and that have already been challenged by senior and consumer organizations as being inaccurate and misleading.

The total cost in appropriated and non-appropriated Department funds dedicated to this ad campaign. Please identify the specific accounts from which the funds are being drawn, and prepare an additional separate breakdown of the cost associated with the production of each television, print, radio and internet ad, and a separate breakdown of the cost of placing the ads before the public.

The name of each business involved in producing or placing the ads; how much each is being paid for their work; and whether the contracts were put out for bid.

The names of the locations in which the ads are being placed.

An accounting of other instances in which the Department used funds to advocate for a specific program or legislation.

During a time when we are asked to rein in spending and use taxpayer money wisely, why is it acceptable to spend this money on an ad campaign, particularly when it is discussing a benefit that will not even be implemented until 2006?

American families should not have to pay for this sham advertising campaign, especially for partisan political gain. We look forward to your prompt response.

Sincerely,

ROSA L. DELAURO,
Member of Congress.
FRANK PALLONE,
Member of Congress.
BERNIE SANDERS,
Member of Congress.
TOM ALLEN,
Member of Congress.
JAN SCHAKOWSKY,
Member of Congress.
RAHM EMANUEL,
Member of Congress.
MARION BERRY,
Member of Congress.

LETTER SUBMITTED FOR THE RECORD BY HON. ROSA L. DELAURO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

DARA CORRIGAN, ACTING PRINCIPAL DEPUTY INSPECTOR GENERAL,
DEPARTMENT OF HEALTH AND HUMAN SERVICES.
February 5, 2004.

DEAR MS. CORRIGAN: We are writing to request an investigation of the Department of Health and Human Services (HHS) involvement in a taxpayer-funded advertising campaign to promote the administration's Medicare bill. Specifically, we are concerned that this effort is a use of taxpayer funds for political purposes and that the administration will be using its own campaign operatives to place the ads.

On February 3rd, the White House announced that it will use $9.5 million from HHS for a television ad campaign to "rebut criticism of the new Medicare law". In addition, $3.1 million will be used for newspaper, radio and Internet ads in both English and Spanish. Why would the administration undertake this program 2 years before the program is to even start.

It has also come to our attention that a media firm currently working for the President's re-election campaign has been hired to purchase the $9.5 million worth of television ad time for this new commercial. National Media Inc. stands to make a windfall from this campaign. This is the same company that has been repeatedly hired for ad campaigns primarily funded by the Republican party and by the drug industry. National Media Inc. has done ads for Citizens for Better Medicare, a drug industry front group that has spent tens of millions of dollars on ads attacking lawmakers interested in lowering the cost of prescription drugs.

Therefore, we would like you to conduct an investigation that focuses on the following:

Is it legal to use taxpayer money to fund this advertising campaign?

Does the ad campaign violate Federal law under 31 USC 1301(a), dealing with the appropriate application of funds, and 5 USC 7321(a), dealing with political participation?

Has any other administration conducted an informational campaign 2 years prior to implementation?

Why was the decision made to purchase the time through National Media, Inc., rather than through the firm that created the advertisements? Was any individual from the White House involved in the selection of National Media, Inc.?

Was the selection of the advertising firm competitively bid?

How were the media markets where the ads will run selected? And what relationship do those markets have to the 2004 Presidential campaign?

During a time when we are asked to eliminate or cut critical programs, we want to ensure that the administration is not using taxpayer money for partisan political gain. We look forward to you investigating this matter promptly.

Sincerely,

ROSA L. DELAURO,
Member of Congress.
FRANK PALLONE,
Member of Congress.
SHERROD BROWN,
Member of Congress.
BERNIE SANDERS,
Member of Congress.
TOM ALLEN,
Member of Congress.
MARION BERRY,
Member of Congress.
JAN SCHAKOWSKY,
Member of Congress.
RAHM EMANUEL,
Member of Congress.

LETTER SUBMITTED FOR THE RECORD BY HON. ROSA L. DELAURO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

MR. LESLIE MOONVES, PRESIDENT, CBS TELEVISION.
February 10, 2004.

DEAR MR. MOONVES, We understand that CBS is currently running advertisements produced by the U.S. Department of Health and Human Services (HHS) on the subject of the recently enacted prescription drug legislation. We urge the network to suspend airing these ads pending the outcome of an ongoing General Accounting Office investigation into the propriety of the Department's alleged expenditure of taxpayer funds on these ads, which are essentially political in nature.

On February 3, the HHS revealed that it will use $9.5 million for a television ad campaign to rebut criticism of the new Medicare law. At this point in time, government investigators have questions about the source of the funds used, and the means under which the production and media contracts have been let.

In addition, it has come to our attention that the media concern hired to purchase the air time is also employed by the President's reelection campaign. It is well known that the firm in question, National Media Inc., also does substantial work for the Republican party and the pharmaceutical industry.

Because of these concerns, the General Accounting Office is conducting an investigation into the matter, and a number of Members of Congress have asked the HHS Inspector General for answers about it.

Given the extremely questionable origin of the ads and the overtly political nature of their content, we hope that as a matter of fairness, your network will at least suspend running them until some of these questions can be answered.

Thank you for your attention to this matter. We look forward to hearing from you.

Sincerely,

ROSA L. DELAURO,
Member of Congress.
RAHM EMANUEL,
Member of Congress.

Ms. DELAURO. Thank you. Media reports on this issue of the ad campaign early on talked about the $9.5 million, quote, "to build public support for the new Medicare prescription drug law, seeking to rebut or counteract criticism." And that was the purpose of the ad campaign.

All of us in this business are subject to tremendous criticism. Wouldn't it be nice if we had $9.5 million or $12 million in a fund to allow us to combat that? We don't.

You talk about the ad campaign as public information. My question to you is, quite honestly, what kind of a public information campaign leaves out critical information for seniors?

Let me mention this. The ads don't tell seniors who enroll that they will pay more in premiums in some instances than they will receive in benefits. The ads do not educate seniors about the gap in their prescription drug coverage.

The ads don't tell seniors that many medicines that they take will not be included on the formulary of the plan in which they enroll. The ads don't tell the seniors that the CBO and independent budget analysts say that potentially almost 3 million seniors will lose coverage as a result of the legislation.

The ads don't tell seniors or the disabled that with dual eligibility for Medicaid and Medicare, they will be forced to pay more for drugs. The ads do not tell seniors that they are prohibited from using their money to buy supplemental coverage.

The ads do not tell them they will pay a substantial penalty if they wait to enroll in the drug plan. And the one piece of information that is in there on the discount cards, quite frankly, doesn't even tell them that it does not provide a discount for all medicines.

And this is a program that is going to start in the year 2006.

It seems to me that we are, in fact, rebutting criticism, counteracting questions about the law, and we are not engaging in a public information campaign. And I say to you, what kind of a public information campaign leaves out this kind of critical information for seniors?

Secretary THOMPSON. Well, Congresswoman, I can tell how passionate you are against the ad, and all I can tell you is that we had the ad reviewed by many different independent groups before it was publicized.

Ms. DELAURO. Can you tell us who those groups are? Give us a list of the individuals that the ad was scrubbed with.

Secretary THOMPSON. Sure. And these past 2 weeks, I am entering into a new promotional program on prevention that we are going to be rolling out in the month of March, that we are raising the money privately for, as well as some other ways. I had a bunch of individuals that I would say predominantly were on your side of the aisle in my office, experts insofar as advertising, and they all indicated the ad was very effective and they did not see anything political about it; and I will be more than happy to share that with you. We played the ad for them, and I don't think there was a Republican in the group.

Ms. DELAURO. Same Medicare, more benefits. It really defies imagination.

Thank you, Mr. Secretary.

Mr. SHAYS. Thank the gentlelady.

And at this time we will go to Mr. Scott, then Mrs. Capps, and then Mr. Emanuel and Mr. Davis, and then Mr. Edwards.

Mr. SCOTT. Thank you. Thank you, Mr. Chairman.

And thank you, Mr. Secretary. As you know, I have an interest in discrimination, and when you talk about religious discrimination, it overlaps with race because some religious organizations are all one race or another. Some churches are all black, some are all

white, so if you can discriminate based on religion, you have the wherewithal to discriminate based on race.

As you know, the Head Start bill that passed the House has a provision in it that allows discrimination. And my simple question to you is whether or not your position is that the Head Start program needs to be amended so that a sponsor of a Head Start program can tell a prospective teacher that you were the best qualified, but we just don't hire Jews. Or you were the best qualified, but we only hire people that belong to our church, which everybody happens to know is all white.

Which way should the weight of government come down on? Should it protect the minorities trying to get a job or the sponsor trying to discriminate?

Secretary THOMPSON. Well, you know, Congressman Scott, that I am absolutely opposed to any type of discrimination. As I understand, this proposal was put in at the behest of a lot of the religious, faith-based organizations because they want to level the playing field.

Mr. SCOTT. They want to discriminate—the level playing field is no discrimination on a Federal contract.

Secretary THOMPSON. Well, all I can tell you is, that was the reason for the language. I will be more than happy to review it again, but I was led to believe that there is no discrimination whatsoever.

Mr. SCOTT. OK. So you have offered no support for the idea that is responsible for——

Secretary THOMPSON. I support the reauthorization of the Head Start bill.

Mr. SCOTT. But you don't believe that the sponsor of a Head Start program should tell a prospective teacher that we just don't hire Jews. You were the best qualified; we just don't hire your kind.

I don't think that ought to be the new law.

Secretary THOMPSON. Well, I certainly would like to have the opportunity to review that.

Mr. SCOTT. When you were Governor of Wisconsin, you wouldn't allow that in Wisconsin, would you?

Secretary THOMPSON. I probably would have some second thoughts.

Mr. SCOTT. I know you would.

Is it the policy of HHS to directly fund religious programs, even if the religious program is not directly paid for with Federal money? For example, if there is a drug counselor program and the drug counselor is paid with Federal money, can the pastor or choir director come in and conduct worship activities during the government-funded program or not?

Secretary THOMPSON. I wish I had had some advance knowledge of this. I would have been more up to speed on it.

All I can tell you, Congressman, is that the faith-based organizations, I think in the past have been discriminated against by legislation; and the President and this administration want to give faith-based organizations an opportunity to be able to apply and not be discriminated against in getting grants.

Mr. SCOTT. Eight percent of the Head Start programs today are run by faith-based organizations without allowing them to discrimi-

nate and without funding religious activities. Catholic Charities gets a billion dollars a year—before this administration came in.

So if you are not prepared to answer, that is fine, because it is a very specific question, and you can get in trouble if you give the wrong answer.

Secretary THOMPSON. I would like to have you submit it, and I will be more than happy to respond to it.

[The information referred to follows:]

MR. THOMPSON'S RESPONSE TO REP. ROBERT SCOTT'S QUESTION REGARDING THE FAITH-BASED LEGISLATIVE INITIATIVE

PRESERVING THE INTEGRITY OF FAITH-BASED ORGANIZATIONS THAT RECEIVE FEDERAL FUNDS

It has been settled for more than 100 years that the Establishment Clause does not bar the provision of direct Federal grants to organizations that are controlled and operated exclusively by members of a single faith. See Bradfield v. Roberts, 175 U.S. 291 (1899); see also Bowen v. Kendrick, 487 U.S. 589,609 (1988). This long-standing right was first codified in Title VII of the historic 1964 Civil Rights Act, expanded by Congress in 1972, and unanimously upheld by the United States Supreme Court in 1987. Justice Brennan wrote in upholding this law, "Determining that certain activities are in furtherance of an organization's religious mission, and that only those committed to that mission should conduct them, is * * * a means by which a religious community defines itself." See Corp. of the Presiding Bishop of the Church of Jesus Christ of Latter Day Saints v. Amos, 483 U.S. 327,342 (1987) (Brennan, J., concurring).

President Bush believes that when faith-based organizations receive Federal funds, they should retain their right to hire those individuals who are best able to further their organizations' goals and mission. An Orthodox Jewish organization, for example, could lose its unique identity as Orthodox Jewish if forced to hire evangelical Christians or others who do not support their mission and beliefs. Forcing charities to choose between cooperating with the government to help the poor and maintaining their religious integrity is not a choice we should force faith-based organizations to make.

Allowing faith-based organizations to hire on the basis of religion when they receive government funds protects the same freedom of association given other federally-funded organizations to define who they are and choose employees dedicated to that cause. For example, an environmentalist group that receives Federal funds can hire only employees who support its position on environmental conservation. A political party receiving government funds likewise can hire only those that agree with its ideology and mission. These organizations' ability to execute their goals hinges on whether they may choose to hire like-minded people. President Bush believes that faith-based groups should not be denied this same right to hire employees who are similarly like-minded.

Head Start is one of the few Federal statutes that require faith-based organizations to give up their protected religious hiring autonomy as a condition of receiving Federal funds under that program authority. The President's proposal for Head Start reauthorization would prevent discrimination against faith-based organizations by explicitly recognizing the right of faith-based groups participating in the Head Start program to retain their religious hiring autonomy even when accepting Head Start funds.

Protecting the rights of religious organizations in the proposed Head Start reauthorization is part of the continuing effort to encourage participation of faith-based organizations. In fact, encouraging the participation of religious organizations in Federal social service programs is not a new notion. Efforts to clarify requirements that had inhibited participation of faith-based organizations in Federal social services program were begun under the previous administration. For example, the Public Health Service Act was amended in 2000 to expressly permit religious organizations providing substance abuse services to receive Federal financial assistance on the same basis as any other nonprofit private organization without impairing the religious character of such organizations or diminishing the religious freedom of individuals. Furthermore, the four Charitable Choice laws passed by a bipartisan Congress starting in 1996 and signed into law by President Clinton explicitly protected religious hiring rights.

In addition to recognizing the right of faith-based organizations to take religion into account in making hiring decisions, the House reauthorization bill would include in the authorization for the State demonstration program a provision protecting the right of parents to choose among pre-school providers participating in the program. In communities in which faith-based organizations participate in a State's demonstration project, parents will have a chance to enroll their children in such programs. Parents would also have the opportunity to enroll their children in a secular program.

Allowing faith-based organizations to complete for government funds while maintaining their religious integrity is part of the President's efforts to use every available resource to fight poverty and despair among America's needy. Of course, the President's Faith-Based and Community Initiative has worked hard to ensure that faith-based organizations receiving Federal funds comply with the constitutional parameters outlined by the Supreme Court. The administration, through Executive Order, regulations and other statements, has repeatedly explained that direct government funds cannot be used for inherently religious activities, such as worship, religious instruction, and proselytizing. Additionally, beneficiaries must have an opportunity to receive federally-funded services regardless of their religion. We are committed to removing barriers to the participation of faith-based organizations in Federal social service programs and to ensure that Federal funds are expended in ways consistent with the Establishment, Free Exercise, and Free Speech Clauses of the First Amendment.

Mr. SCOTT. Thank you. The omnibus appropriations bill has a provision funding Access to Recovery, a voucher program for drug treatment. The language in the bill prohibits—requires programs to meet licensing standards. Let me read the language:

"Conferees direct that all providers participating in the Access to Recovery program should be held accountable to the same standards of care, performance, licensure and certification requirements as other licensed and certified drug and alcohol programs in their respective States."

Can you assure this committee that money budgeted for that program will only go to those programs that meet State licensing and certification requirements, as provided under the law, and that you will monitor those activities?

Secretary THOMPSON. I happen to be a strict believer in the law and will do everything the law tells me I have to do.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

At this time we will go to Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for being here. Your agency has approved a number of comprehensive Medicaid waivers, the goal being expanded coverage. These waivers are a trade-off. States are exempted from requirements and allowed to reduce benefits and raise costs to certain beneficiaries, or current beneficiaries.

In exchange, the States are supposed to increase the number of people Medicaid covers. And HHS has announced in a press release, which you referred to today, that waivers expanded Medicaid coverage to an additional 2.5 million people. However, a recent study by the nonpartisan Kaiser Family Foundation estimated that the waivers only expanded coverage to 200,000 individuals, a tenth of the people HHS has claimed to be covered.

I have a number of questions to kind of get at this issue in our limited time. So you said you were going to be brief. I think these are yes or no questions to start.

Are you familiar with the Kaiser analysis?

Secretary THOMPSON. No, I am not.

Mrs. CAPPS. Well, Kaiser says that the number of newly insured individuals is only 200,000. And I am asking if your estimate counts waivers that were approved but subsequently not implemented.

Secretary THOMPSON. No, the difficulty is that we approve the waiver based upon the information that the State gives us. Now, the State may get in financial trouble and not implement the waiver fully, or not implement the waiver at all and that could be, certainly, a reduction in the numbers.

Mrs. CAPPS. OK. Kaiser did only count waivers that were actually implemented, which would seem like a more accurate analysis. And I am wondering then if your analysis counts individuals that already had health insurance coverage under other public programs, but were moved into the waiver program.

Secretary THOMPSON. We counted those that we approved in State plan amendments as well, and this is a big difference because Kaiser did not include the State plan amendments that we approved. And in our press release we included the waivers plus the State plan amendment that we approved that did expand the coverage for uninsured Americans.

Mrs. CAPPS. And Kaiser only counted individuals who are newly insured because to them and to me it seems a bit disingenuous to claim credit for individuals who already have insurance or already were insured; and I wonder if your estimate counts States' projections of enrollment then, rather than the actual number of people covered under these waivers.

Secretary THOMPSON. We do not collect information on one of these—whether these individuals were previously insured. But we base our information on, predominantly, the information that the State submits to us.

Mrs. CAPPS. It would seem to me that a more accurate account would only count the individuals already enrolled. And it is a particularly relevant topic since a number of States have only partially implemented their waivers or have frozen enrollment in their waiver initiative. So when you look at the actual number of people enrolled in these waiver initiatives who were previously uninsured, the Kaiser Foundation, I think it is hard not to believe that they are only counting the coverage; and this is only 200,000 people, which is a far cry from the administration's claim of 2.5 million people. It seems to highlight a credibility gap for this administration, and I think it raises serious questions about the waiver program.

I am concerned about the cuts in coverage that occur under these waivers. More concerned, in fact, that they may not be accompanied by coverage expansion that we were led to expect. They are being highly touted, and I want us to really understand what they are actually doing. I am also really concerned about the States that don't fully implement the expansions that they have promised to make and that they have been given waivers for. For example, according to Kaiser, Oregon was given a waiver that allowed it to cap enrollment in Medicaid, increase programs and cost-sharing and reduce other benefits. They implemented these cuts. But Oregon also was supposed to cover parents and other adults below 185 percent of poverty.

Now, Oregon isn't alone in this practice and I want to ask very briefly, are you doing anything to make sure that the States live up to their promises in the expansion programs, and not using waivers simply to reduce their cost?

Secretary THOMPSON. Well, we don't use the waivers to reduce the costs. We use the waivers as a way in which we expand benefits.

Mrs. CAPPS. I know.

Secretary THOMPSON. That is the impetus.

Mrs. CAPPS. I understand your impetus, but I believe it really——

Secretary THOMPSON. We monitor. We monitor these waivers. But a good share—you know, we do a have shortage. We have got a huge responsibility.

Mrs. CAPPS. I understand.

Secretary THOMPSON. But I just wanted to say that Kaiser did not include a lot of the things that we approved in the State plan amendment, which really makes a difference.

Mrs. CAPPS. I am just concerned that the most needy in our society now may not be getting the services that they need, and we need more oversight into this

Mr. SHAYS. I thank the gentlelady.

Mr. Emanuel. Excuse me—yes, Mr. Emanuel and then Mr. Davis.

Mr. EMANUEL. Thank you, Mr. Chairman.

Mr. Secretary, thank you and I know you have got the trip and you are going to get ready for it. You are leaving real quickly.

Three quick subjects: On the issue of prescription drug prices and affordability, we have—I think there are two methods on the table to deal with price. And I think, to be truthful, the reason the bill that passed isn't popular and isn't being embraced among seniors is because it fails to deal with the fundamental issue about price and affordability.

Now one method, Congressman Gutknecht and I have led the effort on his legislation allowing the market and competition to give you choice. We would rather than pay 40 percent more, through competition, prices would come down, we would stop ending up subsidizing the French and German and Swiss, British who are basically paying 40 percent less than we do.

The other method is create from Medicare a "Sams Club" and use the 40 million Americans to get the scale that they provide to basically negotiate prices. Your own IG—and I don't know if you know this and in following up on how Congressman Gutknecht had brought to your attention some issues—your IG testified in front of this committee on July 9, 2003. Studied 24 drugs—Medicare buys, veterans' buys—and under those 24 drugs, only 24 drugs picked by your IG, veterans saved 2 billion a year versus what Medicare pays. And quoting this assessment, payment continues to grow as the amount paid by Medicare grows larger; and that bill prevents you from doing what private sector Sams clubs do. Everybody negotiates and uses scale to get better prices.

Now I know what you said earlier. So you are in a box. Maybe you would use the power. Maybe you wouldn't use the power. Maybe if we withdrew competition, that is another method. And

even Mr. Scully, your own CMS director said that relying on the private plans that you mentioned earlier has never been tried and to quote him directly, It doesn't exist in nature.

So that is a cop-out in my view. You could have the power. We know it exists. It is being done by VA and other authorities here in the U.S. Government to get the type of prices and to be fair to our seniors and our taxpayers.

Two other things real quickly, and I will leave you time to answer on your choices. One on the commission to study reimportation, there are over 260 million Americans. I wouldn't pick me to chair it, I am clear in my position. But I surely wouldn't pick Mr. McClellan to chair it either, he is clear in his position.

As far as I could tell, David Kay is available.

I mean, why of 260 million Americans you would pick him. He has already said where he is on this, and if the commission is sincere, it is always going to be questioned now that he chairs it.

And lastly, on the issue of the uninsured, I have a bill. Rather than using a tax credit—it is a bipartisan bill—turning that tax credit into a voucher, allowing me to take that voucher and go into a subsidiary of the Federal Employees Health Benefit Plan and use that scale of 33 working uninsured who have a voucher to go into a pool to get the economies of scale; and I would love for you to look at it and work with your staff if you are interested.

It is bipartisan. You can pick any one of them or ignore them for all I care. That is not true, but go ahead.

Secretary THOMPSON. Well, I am not going to ignore them and I will address all three of them.

First off, in regards to the—let's go to the third one first. Absolutely. You know you have been over to see me. I told you I had some ideas. You said you had some ideas. I said I would love to work with you on a bipartisan basis to come up with a program on the uninsured.

Mr. EMANUEL. I will be waiting for you when you come back from Iraq.

Secretary THOMPSON. And I will be more than happy to do that, and let's see if we can come up with something. And Congresswoman Baldwin and Congressman Gutknecht and anybody else who wants to join us would be—I would appreciate.

Secondly, Mark McClellan, he is an expert. Everybody realizes that. He is an outstanding individual. I don't think that you have to worry one darned bit. But I understand your criticism and your suggestions, and maybe we should have some others. I will review that.

Mr. EMANUEL. Thank you.

Secretary THOMPSON. I can understand where you are coming from on that, but Mark was not that interested in doing it. I wanted him to do it because I trust his judgment a great deal. He is a fine individual.

Third, in regards to negotiations, right now even if I had the authority and the power, Congressman, if the PBMs were going to negotiate with the pharmaceutical companies, what would I do? I mean, we don't know; you know, that is a new system.

But seniors certainly need somebody to do the negotiating for them. I think that the new PBM model is going to work extremely well, and I think it is going to drive down the prices.

Mr. EMANUEL. I trust you more than I do the PBMs. You work for the taxpayers. They are a private company.

Secretary THOMPSON. And I think the thing that is really going to drive it down is this transparency that we are going to put up on the Web page and that you can look at and that everybody can watch.

Mr. SHAYS. Mr. Secretary, you have three members. You have Mr. Davis, Mr. Edwards and myself. Are you able to stay till about 10 after?

Secretary THOMPSON. Yes.

Mr. SHAYS. And your trip—I am not sure that was wise to share with others—is out there, but we do want you to travel safely.

Mr. Davis. I am sorry.

Mr. DAVIS. Thank you, Mr. Chairman.

And, Mr. Secretary, let me try to ask you two sets of questions and give you a chance to respond to them. The first one deals with what Mr. Emanuel was questioning you about at the very beginning, the question of the negotiating authority that the VA has right now.

One would think that we ought to be able to look at that experience and make a set of conclusions whether or not the VA's participation has somehow distorted the market or created some untoward consequences that might tell us something about what would happen if you had some of the negotiating authority. So I want you to identify whether or not there have been any imperfections in the market or any unusual things that have happened that you think might be of any value to us from an analytical standpoint.

And second of all, I want to ask you about a totally different topic which is the corrected disparities report that you are well aware of, involving racial disparities in this country. And I certainly applaud you for acting to issue the correct report and to alter the report language to acknowledge that there is a significant disparity in the country between the health care status of African Americans and Caucasians.

But I want to focus on, frankly, how we got to this point in the first place from an internal standpoint. How did the report get altered to start with? And then what does that tell you about your internal processes at HHS that a document that was prepared, presumably by bureaucrats, people who weren't involved in the political process, had very critical language taken out of it. How did it get sanitized and what steps have you taken to address that problem?

You can answer both of those.

Secretary THOMPSON. I don't know any examples that there are distortions in the marketplace right now because the VA is purchasing drugs. I don't know of any. They have been doing it for some time and very effectively. I think that everybody recognizes the effectiveness of it.

Whether or not, if you teamed up with what the VA purchases and what HHS would purchase, or could purchase under some new authority, if you gave all the authority to purchase the drugs under

Medicare to one person or one department, whether that would cause a distortion, it conceivably could. I can't guarantee that or I can't tell you that it would. It conceivably could.

In regards to the report, first off, the body of the report, not one word changed in the body of the report. It was the—as I understand it, it was the narrative about the report that was changed to make it more positive. But the body of the report, as I understand it, was not changed at all.

Mr. DAVIS. To cut you off one second, as I understand it, it wasn't just to make it more positive. The conclusion was removed from the report that stated that there were racially identifiable disparities.

Secretary THOMPSON. All I can tell you is, when I heard that, I said, we will issue it. It makes no sense.

Mr. DAVIS. How do you think it happened——

Secretary THOMPSON. I think people just wanted this to be a more positive report and made that editorial position known, and that is what happened.

Mr. DAVIS. Who do you think made that choice? You say people.

Secretary THOMPSON. I am responsible because I am the Secretary, so I am not going to say that, you know, this person or that person—it was a mistake. I corrected it immediately and now everybody knows that, and I will take the blame for it.

Mr. DAVIS. All right. I will yield back my time in the interest of time, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Secretary, for all the good work you do and for being here today. I would like to revisit the issue raised by Congressman Scott regarding the President's faith-based initiative policy.

I absolutely accept your statement that you oppose discrimination of any kind. So let me just ask this question in terms of fact.

Isn't it a fact that this administration's policy is that a group, a private group, may receive $5 million in Federal tax dollars for drug counseling or to provide welfare reform efforts to help in job training; and then with those tax dollars, the administration says it is OK for that group to say, I am not going to hire you for solely one reason—because I don't like your religious faith.

My question is, isn't that a fact that the administration supports that policy, the ability to discriminate in job hiring even when using Federal tax dollars, based solely on an American citizen's personal religious faith?

Secretary THOMPSON. The administration believes that faith-based organizations have been discriminated against in the past, and what they are trying to do is to correct that and allow faith-based organizations to get grants and dollars equal to what other organizations do and allow religious organizations to hire people of that religion.

Mr. EDWARDS. Mr. Secretary, I don't think you directly answered the question. I know you stated what the administration's trying to do. So I will just make a statement with the time I have.

The fact is, the administration is saying that it is OK for a group to receive $5 million for a drug counseling program, and then say

to a job applicant, even when tax dollars are involved, we are not going to hire you because you are Catholic or Jewish, or we are not going to hire you because you don't pass our personal religious test.

I find it extremely ironic that an administration claiming that what we should try to do is stop discrimination against faith-based groups, says it should be the policy of the U.S. Government to subsidize religious discrimination and religious bigotry.

Let me ask you—a second issue on that question of, is the administration following through with what it says it believes, the issue of "no child left behind?" Am I correct in looking at some of the numbers put together by the Democratic staff of the Budget Committee that this budget actually would cut 450,000 children off of child care services over the next 7 years?

Is it a 15 percent reduction in the real investment for Federal child care programs? If so, how does that comply with the philosophy of "no child left behind"? That is a lot of children being left behind.

Secretary THOMPSON. First off, I just wanted to point out that the individual receiving the services is guaranteed to receive all services.

Mr. EDWARDS. Right. But to clarify that, Mr. Secretary, because I don't want this to be misunderstood, the fact is this administration says if you are applying for a federally funded job, a group may legally say that we are not going to hire you because you are Catholic or Jewish or Methodist or Hindu, or because you don't pass our private religious test. I find that deeply offensive.

But go ahead and please answer the second question.

Secretary THOMPSON. The second one, in regards to the projections out, these are projections made by OMB and these are projections that are going to mathematically get to one-half of the deficit by 2009.

But, you know, that the budget is submitted each year. I didn't have any input into putting the long-range projections in. I helped prepare the budget for 2005 for my Department. If I am here in 2006, I will be putting together a budget based upon the facts and figures and the evidence I have at that time.

Mr. EDWARDS. I accept that. But just to make the facts clear, if the administration is asking the American people to believe the numbers they are presenting on their 5-year budgets, I assume they are telling the American people these are honest numbers factually. This is a 15 percent cut in child care services that would result directly in 450,000 children losing their care services.

I am not suggesting you support that policy, but that is the fact of this budget proposal.

Thank you, Mr. Secretary, for all the good things that you do.

Secretary THOMPSON. Thank you, Congressman Edwards.

Mr. SHAYS. Thank you, Mr. Secretary. I am the last one, and then you are on your way.

I first want to say to you that in my judgment, you have been the finest and most outstanding Governor that I have ever seen in my political life, and the fact that we could get you to serve as Secretary where you have been truly outstanding, I just—I applaud you for what you have done as Governor and I know that members

on both sides of the aisle would join me in applauding the job you have done as Secretary.

In dealing with this whole issue of whether or not you could play a role in setting prices for prescriptions, when we asked CBO to look at this, given this was designed to be a private providing plan, they said, we estimate that striking that provision which would have a negligible effect on Federal spending because CBO estimates that substantive savings will be obtained by the private plans and the secretary would not be able to negotiate prices that further reduce Federal spending to a significant degree. The whole logic was that we had these private plans right now negotiated.

They have millions of members, and now we are going to add the Medicare members on top of that. We think they are going to be able to renegotiate prices, make them lower than they have already made them, not just for Medicare, but for others that they have in their plans. And so, there was no logic to put you into this system, because we don't have one system for all.

Do you find anything that I said——

Secretary THOMPSON. Absolutely not. You are absolutely correct, as you usually are, Congressman.

Mr. SHAYS. Thank you. But with regards to the whole issue of the plan itself, isn't it true that we never promised that this plan would solve everyone's problem?

Secretary THOMPSON. That is right.

Mr. SHAYS. We made it what we thought was affordable, and even if I thought the estimates were $400 million—billion, I always assumed they might be double. But I wasn't going to go with a plan that started out at $800 million because I thought that might go double.

So we have always anticipated this plan is going to cost more.

But isn't it true, if we have the money, we can make it more generous? All we simply have to do is pass legislation that will make the plan more generous; isn't that true?

Secretary THOMPSON. It is in the power of the Congress to do that at any time they want to.

Mr. SHAYS. Now, do you find it objectionable that we would have this plan fully take impact on 2005—excuse me, at the beginning of 2006, giving people time to understand this plan, but that we start.

When Ms. DeLauro said the plan doesn't even begin until—isn't it true that in the next few months people are going to be given a card, that they are going to be able to take this card and have major purchasing power and see their drug costs go from 10 to 25 percent reduction?

Secretary THOMPSON. Absolutely. The cards are going to be rolled out in May, and people start enrolling in May, and June 1, they can use their cards effectively. And we believe with the transparency on the Web page that we put up, it is going to have a huge tendency to drive down the prices. We think it is going to be more than 10 to 25 percent.

Mr. SHAYS. So for $35 a year they will get a card that will basically help reduce the price 10 to 25 or maybe even 35 percent?

Secretary THOMPSON. Absolutely.

Mr. SHAYS. Now even if they buy this card, they are not locked into participating in the program because it is my understanding—and I just want to make sure I am true—that they have to make this decision next year, sometime in the fall, and it will stretch into the next year?

Secretary THOMPSON. That is correct.

Mr. SHAYS. So—the end of 2005, end of 2006, so people have lots of time to decide whether they want to be part of this program and in fact they can still participate with the card.

Secretary THOMPSON. Absolutely. There is no preclusion whatsoever. They can have that card immediately, and we want them to have it. We want every senior to have it.

Mr. SHAYS. Now, let me just have you react to this final thing. There are approximately 43 million Americans who are uninsured. They get health care if they go to a hospital, but they still are uninsured; and they might have people hound them for their payments, and so that is not pleasant, to say the least. But the statistics I look at that there are 7.3 million or 17 percent of the uninsured who make over $75,000 dollars. What does that tell you?

Secretary THOMPSON. It tells me and I believe it tells you that those individuals have made a conscious decision that they don't believe they are going to get sick and they don't need health insurance and don't want it. We think it is 18 percent, but 17 percent is great.

Mr. SHAYS. OK. Well, you know what, maybe my math was wrong.

At any rate, wonderful to have you here. You have a very large Department. You have done a great deal to get that Department moving in a very effective way and we certainly appreciate the work you have done.

Secretary THOMPSON. Thank you very much.

Mr. SPRATT. I would only echo the chairman. Thank you for coming and thank you for your forthright answers. We look forward to working with you.

Secretary THOMPSON. Thank you very much, Congressman. All of you, thank you.

Mr. SHAYS. And travel safe.

This hearing is adjourned.

Wait. I am sorry; we have second panel. I am very sorry. We will just stand at ease a second.

[Recess.]

Mr. SHAYS. Mr. Weil, I would like to welcome you here. You have given very good information to this committee, and I thank you for waiting to be part of the second panel, but I guess if you follow the Secretary, it is not a bad thing. So you have the floor and you have the flexibility to make your statement as you would like.

Mr. SPRATT. Mr. Chairman, could I say one word of welcome to him?

Mr. Weil, first of all thank you for coming. And secondly, I am sorry that we don't have more here, but your statement is excellent. I have read it as the hearing has gone on. We will see to it on our side that copies of the statement are not only entered in the record but made and given to the Democratic members of the committee, because I think you have done an excellent job. And you

have got two members here who will be listening very intently. So thank you very much for your participation.

Mr. SHAYS. Actually, it is kind of my favorite when the members leave and we get an opportunity to get into more depth. So thank you.

STATEMENT OF ALAN R. WEIL, DIRECTOR, ASSESSING THE NEW FEDERALISM, THE URBAN INSTITUTE

Mr. WEIL. Well, thank you, Mr. Chairman, Congressman Spratt, and I appreciate those words of welcome.

My name is Alan Weil. I am a researcher at the Urban Institute here in Washington and former Director of the Colorado Medicaid Agency. My remarks will focus on how the proposed budget will affect Americans' health insurance, a topic that you all spent some time on with the Secretary.

Last month the Institute of Medicine released a report documenting the consequences of having 43 million Americans without health insurance and calling for universal coverage by 2010. Unfortunately, the President's budget will move us away from this goal.

I reach that conclusion for three reasons:

First, the proposed budget fails to provide the resources necessary to increase health insurance coverage.

Second, the proposals included in the budget are not directed at those who most need assistance and, in fact, may undermine coverage that currently exists.

And, third, the budget ignores the critical role States play in providing health insurance and puts States in a worse position to meet their citizens' needs.

Now, the President's budget proposes a modest tax credit for low-income people who purchase health insurance in the individual market, although, as has been noted, the budget does not identify a source of funding for this portion of the proposal.

Appropriately designed tax credits could play a constructive role if part of a comprehensive approach to covering the uninsured, but the credits proposed in the budget suffer from five problems.

The most serious problem with this tax credit is availability. The proposed credits can only be used in the individual market where insurers routinely deny coverage to those with identifiable health problems and write coverage that excludes certain conditions. Health insurance simply will not be available to those who most need it, regardless of the size of the tax credit.

The second problem with tax credits is adequacy. The $1,000 to $3,000 credit falls far short of the cost of an insurance policy. Newly insured tax credit users will primarily end up in plans with high deductibles and copayments, causing them to defer needed care, risking bankruptcy if they get sick, and continuing to burden the health care system with uncompensated care.

The third problem with tax credits is the amount. Tax credits suffer from what I call the Goldilocks problem. A credit large enough to entice a significant number of people to buy insurance is also large enough to disrupt the employer coverage on which more than 100 million Americans rely. A credit small enough to avoid harming the employer market is too small to help the unin-

sured. In the end, there is no such thing as a tax credit that is just right.

The fourth problem with tax credits is administration. Many families will be unaware of the credit. They will fail to take advantage of it, or they won't take it in advance because they will worry about having to pay the government back.

And the fifth problem with tax credits is accountability. When individuals face rising premiums, disputes over coverage, or concerns about quality, there will be no one there to help them.

Now, the President also proposes, as you have discussed, a tax deduction for the premiums paid for catastrophic health insurance coverage. But that provides no benefit to the vast majority of people currently without insurance coverage. And the budget encourages the formation of association health plans, but they offer almost no benefits to the uninsured as well.

Now, with respect to Medicaid, which is the cornerstone of existing coverage for low-income Americans, the budget resurrects last year's proposal to convert the entire program into a block grant. Medicaid block grants are a bad idea, and the Nation's Governors were right to reject them last year. The premise of the block grant proposal is that Medicaid is inefficient. But Medicaid's high costs are due primarily to the complex needs of the elderly and disabled people it serves, not to program inefficiencies.

The options States would gain through block grants to scale back benefits and increase copayments will not generate substantial savings. Block grants shift the financial risk of meeting the most vulnerable Americans' needs to the States, where revenues are more volatile and tax bases are narrower. And block grants lock in current inequities across States.

I believe actually that Medicaid block grants would have the ironic effect of reducing creativity and innovation at the State level. Why? Because money is necessary for States to undertake innovations, and the block grant structure, by shifting costs and risk to the States, will end up making States more conservative in their behavior.

Now, the President's budget also does not propose to extend the enhanced Federal matching rate that was instrumental in keeping Medicaid cuts to a minimum last year, and it fails to extend the time States have to spend their SCHIP funds. Meanwhile States are facing new administrative and programmatic costs associated with the prescription drug bill. Together, these provisions reduce the resources States have to meet the health care needs of their residents.

In sum, the budget provides inadequate resources to address the needs of the uninsured. The substantive provisions in the budget offer benefits primarily to the healthy and wealthy and take them away from the sick and the poor. And the budget leaves States bearing a larger share of health care costs in 2005 than they did in 2004, even as State revenues remain relatively flat. While States may ultimately wield the axe of health insurance coverage cuts, this budget helps aim the blade.

I encourage your critical review of the administration's 2005 budget for the Department of Health and Human Services so we can make progress toward the goal of ensuring health insurance for

all Americans. I greatly appreciate the opportunity to be here and would be happy to answer questions that you might have.

Mr. SHAYS. Thank you very much, sir.

[The prepared statement of Mr. Weil follows:]

PREPARED STATEMENT OF ALAN R. WEIL, DIRECTOR, ASSESSING THE NEW FEDERALISM, THE URBAN INSTITUTE

The views presented are those of the author and do not necessarily represent those of the Urban Institute, its trustees or its sponsors.

Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you today to discuss the President's proposed 2005 budget for the Department of Health and Human Services. My name is Alan Weil and I direct the Assessing the New Federalism project at the Urban Institute, a non-profit, non-partisan research institute in Washington, DC before coming to the Urban Institute I was executive director of the Colorado Department of Health Care Policy and Financing, which is the state Medicaid agency.

While the HHS budget covers many topics, I will focus on how it will affect Americans' health insurance coverage. Last month, the Institute of Medicine (IOM), which, as part of the National Academy of Sciences, has a charter granted by Congress to advise the Federal Government on scientific matters, released a report calling for universal health insurance coverage in America by 2010. The report, which was the culmination of 3 years of study, documented the huge cost to the nation, to communities, to families and individuals for leaving this problem unaddressed. It called for leadership from Congress and the administration to achieve the goal of universal coverage. Knowing that solving this problem would take some time, the IOM also recommended that existing sources of public insurance coverage be maintained so the problem does not get even worse in the interim. And the report reminded us that there are 43 million Americans without health insurance—a figure that has grown by 3 million in the last 3 years.

Unfortunately, the proposed 2005 budget fails to provide the leadership the nation needs in addressing the problem of the uninsured, and it fails to protect the existing coverage most Americans have. This budget represents a step backwards when it comes to one of America's most important challenges: covering the uninsured.

There are three ways of considering how the President's budget will affect the uninsured. First, the budget includes a few proposals specifically designed to address this topic. Second, the budget includes a number of provisions that affect Medicaid, which is the cornerstone of coverage for low-income Americans who would almost certainly be without insurance coverage if they did not have Medicaid. Third, the budget affects the costs and funds states have available to meet their residents' health care needs. I examine each of these areas in turn to reach some overall conclusions regarding the effects of the budget on the uninsured.

PROPOSALS FOR THE UNINSURED

The President's budget proposes three policies specifically targeted at the uninsured.

First, the President "proposes" a modest tax credit for low-income individuals and families that purchase health insurance in the individual market—that is, who buy it on their own and do not receive it through their employer. I put "proposes" in quotation marks because the budget does not include funding for this measure. This makes it difficult to take the proposal seriously, since the administration can only advocate for these provisions if they identify offsetting savings—something they have thus far declined to do.

Appropriately designed tax credits could play a constructive role if they were introduced as part of a comprehensive effort to provide health insurance to all Americans and they were used in conjunction with expansions of public coverage for low-income people. However, in the President's budget tax credits stand alone and therefore must be judged alone for their ability to meet the needs of the uninsured. Many people have written about the shortcomings of tax credits as an approach for reducing the number of people without health insurance. Tax credits suffer from five problems—problems of availability, adequacy, amount, administration and accountability.

Availability. The most serious problem with tax credits is that of availability. Most tax credit proposals, such as the one offered by President Bush, are designed to encourage people to purchase coverage in the individual health insurance market. Insurers in this market routinely deny coverage to those with any identifiable health problems, or they write coverage that excludes conditions or body systems

where there is any history of medical problems. When coverage is offered, rates are many times higher for older adults than for those who are younger. Administrative costs routinely exceed 30 percent of the premium. Given the current state of the non-group market, health insurance simply will not be available to those who most need it, regardless of the size of a tax credit.

Adequacy. The second problem with tax credits is that of adequacy. The size of the credit—$1,000 for an individual and $2,000 to $3,000 for a family in the President's proposal—falls far short of the cost of health insurance. Since few families of modest means can or will pay the difference between the credit and the cost of a typical health insurance plan, newly insured tax credit users will primarily end up in plans with deductibles and copayments that run in the thousands of dollars, with many excluded services or significant limitations on coverage. These limited benefit packages will leave families in exactly the position they find themselves today: deferring needed care because of cost, at risk of bankruptcy if they get sick, and placing a tremendous financial burden of uncompensated care on the entire health care system.

Amount. The third problem with tax credits is that of the amount. Tax credits suffer from what I call the goldilocks problem. That is, a credit that is large enough to entice a significant number of people to buy health insurance in the individual market is also large enough to cause serious disruption in the employer market, thereby jeopardizing coverage for a much larger number of people. A credit that is small enough to avoid harming the employer market is too small to help very many of the uninsured. Most tax credit proposals seek the middle ground, but there is no such thing as a tax credit that is "just right."

Another often ignored problem with setting the amount of the credit is how it will interact with existing or potential state policy choices with respect to public coverage through Medicaid and/or SCHIP. The presence of a tax credit large enough to help an individual purchase coverage will also reduce the incentives states have to retain or expand optional coverage in public programs that require the state to pay a portion of the bill. Faced with the choice between a fully federally funded tax credit or a matching Medicaid or SCHIP program, states have a clear incentive to rely upon the former. This scaling back of state effort would yield fewer people with comprehensive insurance coverage and a larger fiscal burden for the Federal Government.

In short, it is impossible to set a credit amount that strikes some theoretically correct balance between helping no one and undermining the existing public and private health insurance system.

Administration. The fourth problem with tax credits is that of administration. At a minimum, a tax credit must be refundable and paid in advance if it is to help a working family purchase coverage. Unfortunately, even with these provisions many families will be unaware of the credit, fail to take advantage of it, or not take it in advance because they will worry they will have to pay the government back if they receive a small wage increase during the year.

Problems of administration arise in part from the desire to use the tax system to effect a goal that is inconsistent with its primary purpose. Although recent provisions, such as the EITC and the child care credit, have included similar features of refundability, neither of those credits involves the same complexity as that of the proposed health insurance tax credit. For example, eligibility for the health insurance credit is based upon the absence of something else—employer sponsored insurance and public insurance—which must be verified. Health insurance is bought by family units that do not necessarily align with tax filing units. The tax code is very good for changing marginal incentives but it is an awkward tool at best for achieving health insurance coverage.

Accountability. The fifth problem with tax credits is that of accountability. Most people rely upon their employer or a public agency to provide them information about their health plan, assist with problems, and monitor the quality of coverage. But people in the individual market are on their own. If their coverage is cut, their premiums rise, or there is a dispute over their benefits, they must fend for themselves. If the Federal Government is providing financial incentives to purchase coverage, individuals will expect the Federal Government to address these problems. Consumer outcry among those who are denied coverage or who feel mistreated by their health plan will create immense pressure for the Federal Government to do something.

Overall, the President's proposed tax credits will only help a very small number of people purchase health insurance, are inefficient as a matter of health policy because they will mostly be used by people who already have coverage, and they put at risk the coverage many people now have through their employment.

The President's second proposal is to provide a tax deduction for the premiums people pay for catastrophic health insurance purchased in conjunction with the establishment of a Health Savings Account (HSA). This proposal offers no new coverage for the uninsured and threatens to increase costs for people most in need of coverage.

It can be debated whether HSAs will achieve their stated goal of turning patients into price-sensitive, value-seeking consumers. What cannot be debated is that every person who gives up comprehensive health insurance coverage and shifts to catastrophic coverage is moving from a broader risk pool to a narrower one. It can be debated whether HSAs are only a good deal for healthy people. What cannot be debated is that HSAs are a better deal for healthy people than they are for sick people, and they are a better deal for wealthy people than they are for poor people. Inherent in the HSA approach is the tendency to divide the health insurance risk pool between high and low risks and between rich and poor. While the extent to which this division will occur can be debated, the tendency for it to occur cannot.

The only possible consequence of providing a tax subsidy for the purchase of catastrophic coverage is to even further skew the benefits of HSAs to the rich. After all, a tax deduction offers the most value to people with the highest incomes, and is of little or no value to the typical person without health insurance.

Thus, at best, the budget proposal helps the wealthiest Americans while doing nothing for the uninsured. But at worst, the proposal increases the incentive for healthy people to leave the broader risk pool, thereby increasing premiums for everyone else, and making it harder for employers to continue providing coverage to their employees. This is a step in the wrong direction when it comes to addressing the needs of the uninsured.

While not actually in the budget, the President also proposes to permit the formation of Association Health Plans that can purchase insurance coverage for a group while being exempt from state insurance regulations. The best thing that can be said about this proposal is that it does not cost any money. However, this proposal shares the fundamental weaknesses of the other two proposals in the budget: it encourages fragmentation of the risk pool and it does nothing to address the fundamental reason so many people are without health insurance, which is cost.

In sum, the three proposals related to health insurance coverage represent a flawed and ineffective set of approaches to reducing the number of Americans without health insurance. All three fragment the risk pool, which means that, to the extent anyone benefits from the proposals, the benefits will flow to people who are healthy and not to those with the greatest need. Two of the three rely upon changes in the tax code to encourage individuals to change their behavior, which has a failed track record in the area of health insurance. And the only one of the three that is funded directs its funds to higher income people.

Most disappointing is that elsewhere in the budget the President touts the success of the State Children's Health Insurance Program (SCHIP). While SCHIP has its limitations, it does provide a comprehensive set of benefits to the neediest children and it does not discriminate against those who are sick. Given the choice between building upon programs like Medicaid and SCHIP that have a proven track record of providing access to health care services to needy Americans, and experimenting on the poor with new theories like tax credits and tax-preferred savings accounts, this budget reflects the wrong choice.

MEDICAID PROPOSALS

In order to understand the implications of the President's budget on the uninsured, it is also important to examine how the budget affects the Medicaid program. Medicaid is the cornerstone of the nation's policy on covering the poor, reaching 50.7 million people.

The President proposes a handful of changes in the Medicaid program, many of which are small, but positive steps for the program. However, there are two large proposals that would have more substantial effects on the program.

The budget proposes changes designed to limit a series of strategies states have used to obtain Federal matching funds. The overall goal of improving Medicaid's fiscal integrity is a worthy one. However, this initiative has two shortcomings.

First, barriers to state financing schemes can also impose undue barriers to legitimate state efforts to finance their programs. At a time when state resources are particularly tight, states can ill afford to have the Federal Government block their appropriate efforts to preserve the funding they need to administer their Medicaid programs.

Second, this initiative, if successful, will remove funds from the Medicaid program at a time when the needs of that program are growing. The President's budget does

not propose to plow the savings this initiative generates back into the Medicaid program or into other efforts to meet the health care needs of low-income people.

The President's budget also indicates a continued interest in converting the entire Medicaid program into a block grant, although specific provisions to make this change do not appear in the budget. The Nation's Governors were right to reject this risky and destructive proposal last year. Another year's time having passed does not make this proposal any better.

Many people have written about the damage Medicaid block grants will cause to the millions of low-income people who currently are enrolled in the program, and to the longer-term fiscal circumstances of the states. In a paper I wrote with my colleague John Holahan we discuss four reasons block grants for Medicaid are a bad idea: they represent a misdiagnosis of the problems facing Medicaid, the flexibility they create is unlikely to generate substantial savings, they shift risk to a level of government less able to bear it, and they lock in existing inequities.

Misdiagnosis. Medicaid is an efficient program. While the program is expensive, this is primarily because of the population it serves. As the President's budget shows, 69 percent of Medicaid spending is attributable to people with disabilities and the elderly—groups for whom private health insurance is not a realistic option. When comparing similar populations, Medicaid costs per person are actually lower than those for private insurance. Thus, the premise of the block grant proposal—that Medicaid is inefficient and block grants would make it efficient—is flawed.

Flexibility does not provide fiscal relief. Our analysis shows that scaling back optional benefits and increasing cost sharing will not generate substantial savings. Under current law states can eliminate certain categories of eligibility and tighten eligibility standards. Even in tough fiscal times states hesitate to take these actions because they know that the Medicaid population has no other alternatives. Block grants would give states the new option of creating waiting lists, but there is little reason to believe states would find this more appealing than the unpleasant options already available to them under current law.

Shifting risk. The primary effect of a Medicaid block grant is to shift the financial risk of meeting the health care needs of the poorest and most disabled Americans to the states. State revenues are more volatile than those of the Federal Government, their tax bases are narrower, and they cannot run deficits. In tight times states are likely to shift these risks to local governments and even to individual enrollees. A health care safety net based on state and local financing is less stable than one that assures Federal financial participation when new needs arise.

Inequities. The current distribution of Federal funding to states is inequitable when considering traditional measures such as poverty rates or the number of people without health insurance. While States' historical choices are responsible for many of these inequities, under current law states that shift direction and cover a new population or service can gain new matching funds. Block grants lock in existing inequities, preventing states that have provided less coverage in the past from being able to draw down additional Federal funds in the future even if they wish to invest in new solutions to their health care problems.

I conclude that Medicaid block grants would have the ironic effect of reducing creativity and innovation at the state level. Why? Because money is necessary for states to initiate real innovations, and the block grant structure, by shifting costs and risks to the states, will make states more conservative in their behavior.

The President's budget does reintroduce a number of proposals made in prior years to strengthen the Medicaid program, and these deserve your support. However, a simple calculation demonstrates how limited these proposals are. Setting aside the continuation of expiring programs, the budget for 2005 includes $182 million for new initiatives in Medicaid, while it makes cuts of $1.9 billion. Thus, on net, this is a budget that scales back support for Medicaid, which is a step in the wrong direction if our goal is to preserve the coverage people currently have.

RESOURCES FOR STATE HEALTH PROGRAMS

The final aspect of the President's budget that will affect the plight of the uninsured is proposals that affect state spending and resources for health care overall. Each year states make key decisions regarding coverage levels in Medicaid and other programs that aid the uninsured. If the Federal Government shifts health costs to the states or fails to support the programs it has created, states are left with less money to meet these health care needs. The budget leaves states with inadequate resources in two areas.

The new Medicare prescription drug law imposed new costs on states. States face new administrative responsibilities and will undoubtedly see higher levels of enrollment in the Medicare Savings Plans (what were formerly called Qualified Medicare

Beneficiaries and Specified Low-Income Medicare Beneficiaries). These new responsibilities and enrollees bring with them additional costs. While a well-designed prescription drug benefit could provide fiscal relief to states by reducing the share of drugs states pay for through their Medicaid programs, the law as enacted seeks to recover most of these savings. States face substantial budgetary uncertainty due to the so-called "claw back" provisions.

Meanwhile, the new Medicare law fails to reflect many of the lessons states learned by implementing prescription drug programs in the years before the Federal Government took action. States learned that administrative simplicity in eligibility standards and benefit design was an essential component of a successful plan. States learned that they had to take an active role in reducing prescription drug costs and not simply rely upon others to achieve savings. The new Medicare drug program creates new gaps and complexities for some Medicaid beneficiaries because it does not mesh well with existing Medicaid policies with respect to cost sharing and formularies. The new and remaining burdens states face as a result will make it harder for states to fund assistance for people without health insurance.

Last year Congress, over the objections of the President, provided fiscal relief for states, half of which came in the form of a temporary increase in the Federal matching rate for Medicaid. This funding boost came just in the nick of time and permitted many states to avert substantial cuts in their Medicaid programs.

The President's budget does not seek the continuation of these enhanced matching funds despite the fact that state fiscal conditions have barely improved from last year. The budget also allows the expiration of $1.1 billion of SCHIP money that could be allocated to states seeking to cover more children.

In total, the President's budget projects Federal Medicaid spending in 2005 that is 3.4-percent higher than in 2004. It would be nice if this slow rate of growth reflected new efficiencies or expectations for low health care inflation. But it does not. A major reason for the low rate of growth is the expiration of the enhanced matching funds, meaning that states will be expected to bear a larger share of Medicaid costs in 2005 than they did in 2004.

While we cannot know in advance the precise effects of this shift in costs from the Federal Government to the states, history provides us with a guide. States will, out of necessity, scale back coverage, eliminate categories of eligibility, and freeze already-low provider payment rates thereby threatening access and quality. These are the unfortunate, but predictable, effects of this budget.

CONCLUSION

The administration's budget is a statement of the President's priorities. The President periodically speaks of the need to address one of the nation's biggest problems: the large and growing number of Americans without health insurance. In evaluating this budget it is necessary to ask whether the funding decisions reflected in it will meet the nation's needs in this area.

Unfortunately, an examination of the budget makes clear that enactment of this budget would be a step in the wrong direction when it comes to the uninsured.

The budget provides no national vision of a solution to the problem. The few proposals it makes in this area offer benefits to the healthy and wealthy at the expense of the sick and the poor. These proposals threaten to undermine the base of employer-sponsored health insurance that covers the majority of Americans, and to unravel the public coverage through Medicaid that is the rope out of which the health care safety net for the poor is made.

In addition, the budget simply ignores the major role states play in preventing the uninsured problem in this country from being even worse than it is. This budget leaves states worse off than they were in 2004 while state revenues remain flat or very slowly recovering from deep troughs. While states may wield the axe of health insurance coverage cuts, this budget helps aim the blade.

Overall, this budget reflects an inadequate Federal commitment to meeting the needs of Americans without health insurance coverage. I encourage your critical review of the administration's budget for the Department of Health and Human Services so Americans can benefit from a budget that is more likely to meet their needs.

Mr. SHAYS. We are going to start with Mr. Spratt, and then I will have some questions. Then we will go back.

Mr. SPRATT. Thank you very much. Your statement makes a good case for building on the system we have got, which is often discredited and disdained, but as I understand it you are saying we would be better off to use the Medicaid program and expand it than we

would to introduce a new payment device like health insurance tax credits.

Mr. WEIL. If we were to build a comprehensive approach that covered everyone, I think we could try different ways of reaching coverage. And the Institute of Medicine report lays out four options, some of which are purely one model, some purely another model. But in the range of options that are under serious consideration, which are very incremental where the resources are so limited, it is essential that you devote those resources to the places that you are most confident you will get your bang for the buck. And today we do have programs like Medicaid and SCHIP with a proven track record of providing coverage and access to low-income people, and then we have this sort of theoretical idea that we are going to use tax credits to try to reach people as well.

And I would argue that the risk of taking the tax credit approach in an incremental world, which is the world you are operating in, is very high. With limited resources, the first dollars at this point ought to go into shoring up and expanding the existing programs.

Mr. SPRATT. Let's talk about some of the existing programs, like the SCHIP program. On page 9—have you read the Secretary's testimony?

Mr. WEIL. Yes, sir.

Mr. SPRATT. Page 9, he has a description of how SCHIP is funded, how their allotments, then their excess funds, and then these excess funds are redistributed among the States and there is $2.2 billion from fiscal year 2000 and 2001 and $1.2 billion in 1998 and 1999 funds. Could you make sense of all that for us and tell us what is going on with SCHIP? What are these funds being used for, and what is the potential use of those remaining unobligated or unspent funds?

Mr. WEIL. I will try to make sense of it. Basically when the SCHIP program began, the authorized funding was at a level that is appropriate to an ongoing program, but when the program started up it was very small, and each year we have seen enrollment go up by about a million people a year. States were given 3 years during which they could spend the allotment that they had, but over the course of those first 3 years, with the growth path, States accumulated so much of the—so many unspent funds, that the 3 years were up, and they were going to revert to the Treasury.

There have been a number of efforts to give States longer and to reallocate the unspent funds to other States that had gone over their allotment. Now, in the end the question is, is Congress going to continue to give States the opportunity to cover as many children as possible with the funds that were initially approved for this program? If you make that commitment, given the start-up time in this program, you have to give States a little bit more time. And I think it is fair to say that this is a program with bipartisan support. It is a program that the Secretary speaks highly of. The President's budget touts the successes of this program. This is a bipartisan program. When States are facing very tight budgets, it seems like the wrong time to take away funds that otherwise would have——

Mr. SPRATT. Let me make an observation at this point. It is also a program, interestingly enough, which was created in the context

of the balanced budget agreement of 1997. In other words, we were able to balance the budget, actually put it in surplus within a couple of years, but at the same time we were able to say there are a few priorities that we are going to squirrel funds away for. In this particular case, we raised the funds with a cigarette tax and then committed it to this particular program. But in any event, it shows that you can still make progress in covering people with health care coverage that they desperately need and at the same time balance the budget. We did it in 1997.

Now, let me ask you also about page 12, if you would also sort of tell us what is going on there with Medicaid. The administration is proposing to cap reimbursement levels to individual, State and local government providers to no more than the cost of providing services to Medicaid recipients. I understand that they are assigning a savings to that broad statement there of about $23 billion.

Mr. WEIL. The administration proposes—and the Secretary spoke about efforts to improve fiscal integrity in the program, and I don't think anyone would argue with the goal of improving the integrity and making the matching formula that is the underpinning of the program work.

The challenge is that although it is very easy to trot out examples of States misusing the matching system, it is equally easy to show examples where States are using the matching system exactly as it was intended to function, by bringing additional dollars in, having State and local governments and local agencies contribute to the program, and obtain matching funds to provide services to low-income families that need health coverage. And in a perfect world, we would divide up those that are legitimate and those that are illegitimate, and we would stop the illegitimate and we would promote the legitimate.

So I would endorse the general notion that the Federal Government should attempt to improve the integrity of the program. A number of the provisions set up administrative burdens, auditing burdens for how States raise their funds and how they move their money around that goes way beyond what I think is appropriate if we don't want to get in the way of States expanding coverage, as they should be permitted to do under the Medicaid program.

I would also just add that if the administration is expecting to be so successful that they can raise this kind of money, I would like to see them propose to plow that money back into insurance coverage, not to spend it on other priorities.

Mr. SPRATT. One final question. You appear to take a rather permissive view of program practices like DSH, disproportionate share payments that States have used in various ways, ingenuity in upper payment limits, simply on the grounds that this is, after all, funneling more money into the Medicaid system and serving a clear and desperate need. Am I reading you wrong?

Mr. WEIL. I don't think I am a permissive commentator when it comes to DSH. In fact, a lot of the evidence for and analysis for the tricks and games that States have played with DSH has come out of work that colleagues of mine at the Urban Institute have done. It is not my work, but I would acknowledge their work.

The point I am making is that if you go back to the original DSH provisions, they were designed explicitly to make—in fact, to re-

quire States to have mechanisms to help those hospitals that provide care to a disproportionate share of uninsured and Medicaid patients to get additional funding to meet the burden of having a lot of patients who can't pay. And that is a legitimate goal and one that we shouldn't throw out just because States have figured out how to become more creative.

Now, in my work and work with my colleagues—and I heard the Secretary talk about it as well—I think we would be well served to rethink how this program is designed so that the benefits more closely target the original objectives of the program.

The reason I made the comments I did is that there are many safety net providers that rely very heavily on those funds, and if all we do is say DSH is a failure or a game or intergovernmental transfers have only been used for negative purposes, we are going to pull a lot of money out from legitimate efforts to provide care to people who otherwise would not have it. And I would hate to see us overreact, but I would not want to suggest that we should underreact either.

Mr. SPRATT. Thank you very much.

Mr. SHAYS. I feel that since you have been so courteous yourself to be a panelist and wait so long, that we should advertise your book. Actually I am holding it up because—a quote in it regarding the disproportionate share hospital payments, or DSH. You say: Fiscal integrity in a matching grant program can only be insured if the program has a defined population, set of benefits and payment structure. DSH has provided an opportunity for fiscal games, because it operates outside such a structure.

Therefore my question is, should DSH be eliminated? And what should take its place if it were eliminated?

Mr. WEIL. I didn't realize there were such risks involved in publishing my thoughts, but I appreciate the advertisement.

Mr. SHAYS. That is only if you become a judge. Otherwise it is pretty harmless.

Mr. WEIL. I do believe that a serious effort to fundamentally redesign the DSH program would be valuable, but I would again say that it would be a mistake to reach the conclusion that all dollars flowing through DSH right now are just games and ways for States to draw down additional funds, because I think the evidence is clear that that is not the case.

Mr. Chairman, I would say this, and to put a few more words around those words that I wrote, I worry that the Federal Government's efforts and the proposal in the budget focus on trying to follow the dollars on the revenue side.

The intergovernmental transfer provisions, what is proposed in the budget is to try to basically audit where the dollars come from. As you know, in this committee, money is fungible and following the dollars is a very hard thing to do. In the long run—and the point I was trying to make in the words that I wrote—it is much better to follow the spending. And if you can build a program that defines who is eligible, for what benefits they are eligible, and has an appropriate amount to pay for those benefits, it is much easier to audit and feel confident that those dollars are being well used than it is to try to audit where the dollars are coming from. And

so in the end I think you are going to have more success if you go that route.

But you will not hear me oppose any effort to try to reconfigure the DSH program. I think its elimination without replacing the objectives it achieves would, however, also be a mistake.

Mr. SHAYS. Thank you. Let me ask you this. There are about, approximately, 40 million under Medicaid, about 40 million pretty much under Medicare, plus or minus.

Mr. WEIL. Medicaid has now passed Medicare.

Mr. SHAYS. So a sizable number. Then we say there are under 43 million who are uninsured. They represent about 15 percent of our population. And I saluted President Clinton for saying we need to insure everyone. I didn't think his solution did it. I am not sure he in the end felt it did either, but it sure helped educate all of us. The sad thing is that we just gave up and didn't keep trying to struggle and work through it.

We have, it is fair to say, an employer-based health insurance system, except for the 80 million Americans who are covered either under Medicare, Medicaid. Is that fair to say?

Mr. WEIL. And excluding the uninsured, yes.

Mr. SHAYS. Right. And we have health care clinics. We have about 10 million covered, getting up to $20 million. That is part of the President's plan. And I am told about half, in essence, are getting insurance under that. In other words, there are uninsured who are getting coverage.

Tell me how I am wrong saying—maybe how I look at this incorrectly—because my logic is originally 10 million under the community-based health care clinics and about half of them are uninsured and getting insurance—are getting coverage, even though they don't have insurance, and we are going to go up to 20, where we think 10 of those million will be uninsured, therefore getting health care coverage in the clinic.

Is it wrong for me to take the 43 million and then subtract 10 million and say we are really down to 33 million?

Mr. WEIL. Congressman, I think it would be wrong. And the reason is that despite the incredible positive role that community health clinics play, they do not offer the full continuum of services that people need. And particularly if you speak with folks who run those clinics, and they are very appreciative of the expansion of the resources that the President has effected during his term, they have great difficulty moving—they are very good at providing primary care. They have great difficulty obtaining the specialty services, the secondary and tertiary care that their patients need. They also have difficulty providing some of the personal care that is necessary to manage chronic illnesses which are very common in the populations they serve.

We do know from the data that the uninsured, even if they get care at clinics, are in poorer health than the insured, controlling for their income and age and everything else, and they get less health care than the insured. So I think it would be correct to say—and it is one of the—this is a good-news story—that moving people who are served in clinics to getting the same health care as people who are insured isn't going from a zero to a 1. It doesn't cost 100 percent of the cost of coverage, because we are already pro-

viding services to this population. But it is not the same as being insured.

Mr. SHAYS. Let me just ask you this final question then—or this area.

If there are about 14 million Americans who are uninsured who make $50,000 or more, and half of that number, about 7 million who make $75,000 or more, what does that tell you, particularly about the 7 million Americans? Are they just, you know, young kids who are making good money, not choosing to get health care? Who are they?

Mr. WEIL. We need to know more about them, but lets—two things we should consider. First of all, these are people in households with income more than X, not making more than X. So when I graduated from graduate school and took my first job and had three roommates and we were all working like your staffs do, you know, not making a whole lot of money, and maybe didn't have health insurance, we would be in a household that was high income. So it is very important to look not just at household income, but at family units or health insurance units, and I think that will give you a different picture.

Second of all, $50,000 is above the median income in this country, and it is a substantial amount of money to live on. But family coverage in many parts of this country is running, for an employer-sponsored plan, in the range of $9,000 a year. So we are still asking a lot of those families—and some of them, if they don't have coverage through an employer, have been written out of the individual market because they have a prior health condition and the insurer simply won't offer them coverage. It is certainly the case that there are people who we could reach, I think, without having to pay the full load to bring them into the insurance market and insurance coverage, but it is a small share of the uninsured.

Mr. SHAYS. Thank you. Is there anything you would like to put on the record before we adjourn?

Mr. WEIL. No. I just thank you for the opportunity. And my written comments, I think, cover some of the other material.

Mr. SPRATT. I would ask that his full statement be included in the record.

Mr. SHAYS. It absolutely will be. Thank you, Dr. Weil, very much. We appreciate it.

Mr. WEIL. You are welcome.

[Whereupon, at 12:33 p.m., the committee was adjourned.]

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