ONE HUNDRED NINTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

JOE BARTON, TEXAS
CHAIRMAN



March 3, 2005

The Honorable Jim Nussle
Chairman
Committee on the Budget
309 Cannon House Office Building
Washington, D.C. 20515

The Honorable John M. Spratt, Jr.
Ranking Member
Committee on the Budget
B-71 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Nussle and Ranking Member Spratt:

As is the custom of the Committee on Energy and Commerce, the Majority and the Minority are transmitting separate Views and Estimates on the budget. These are the Views and Estimates from the Minority.

The President's budget for FY2006 continues the trend of this Administration's budgets of the past two years in which previous surpluses have been turned into deficits. At the same time, many critical domestic programs have been deeply cut. In particular, the budget makes very large cuts in our Nation's safety net. By seeking a reduction in Medicaid spending of $60 billion over the next 10 years, it can be expected that even more Americans will join the ranks of the already 45 million uninsured.

The budget would require all entitlement increases to be offset, but only by cuts in other entitlement programs. On the other hand, tax cuts would not have to be paid for. Moreover, savings on the tax side, such as closing abusive corporate tax shelters, could no longer be used to finance entitlement benefit improvements.

These remarks will be confined to programs within the Committee on Energy and Commerce. A detailed analysis prepared by the Committee's minority staff is attached.

## HEALTH

### Medicaid and Children's Health Insurance Program

The President's budget proposes $60 billion in cuts over ten years from changes to state funding rules, administrative payment cuts, prescription drug payment changes, and limiting asset transfers. The Medicaid program serves nearly 50 million Americans, and its numbers have grown in recent years, particularly as the number of poor households went up for the third straight year and the number losing employer-sponsored coverage has increased. In addition, Medicaid is starting to feel the effects of the baby boom generation resulting in more elderly placing demands on the program for uncovered Medicare benefits.

The budget suggests that some of this $60 billion cut would be offset by $16 billion in new spending, but most of this amount is an increase in the baseline spending for the State Children's Health Insurance program for currently eligible children, who are found to be eligible through new outreach programs. Whether states will be able to cover these additional children remains a question.

While the budget states that it proposes to seek improvements in flexibility and efficiency in the Medicaid program, this may be difficult to accomplish. Notably, Medicaid outperforms private insurance in terms of costs. Medicaid costs less than private sector insurance (30 percent less for adults and 10 percent less for children) after adjusting for health differences. Even looking at per capita cost growth, Medicaid has significantly outperformed private insurance over the past four years: Medicaid cost per capita grew at 6.1 percent, while private insurance grew at 12.6 percent. In addition, most private insurance policies do not include substantial long-term care benefits, so a private sector package would be useless to many individuals on Medicaid.

### Medicare

Medicare spending in FY2006 is estimated to be $394 billion. The President's budget is most notable because it does not address any of the flaws in the Medicare prescription drug benefit passed in 2003 or fix the physician payment problem. There are no proposals to improve the prescription drug benefit (for example filling in the donut), allowing the Secretary to negotiate prices for medicines, fixing problems in the low-income portion of the benefit, or reducing the overpayments to Medicare Advantage plans.

### Public Health

The public health portions of the budget include significant cuts. For example, under the President's plan the Centers for Disease Control and Prevention's budget would be reduced by $550 million. While the Nation's top three causes of death are chronic diseases -- heart disease, cancer, and stroke -- the President proposes cuts in CDC's chronic disease prevention and health promotion program of 6.5 percent, or $60 million. Reductions include programs aimed at

fighting childhood obesity, trauma care, health professions training, food and drug safety, disease prevention, and substance abuse prevention and the like. The American Public Health Association (APHA) has said these cuts are emblematic of the Administration's shortsighted approach to public health in general.

The budget also includes a 64 percent cut to a program for training nurses, dentists, and other health professionals through the Health Resources and Services Administration and a proposal to cut bioterrorism preparedness funding 12.6 percent. According to APHA's Executive Director, "There is no doubt that the bioterrorism funding of the last few years has strengthened the nation's preparedness capability and our ability to deliver public health services. But after suffering decades of neglect, cuts will jeopardize the initial progress we made. Funding must be sustained to rebuild our public health system and to better protect Americans."

## ENVIRONMENT

### Superfund

The President's FY2006 budget request would cut the Superfund program by $102 million from his budget request last year. The budget provides no justification for this reduction, which comes at a time when the lack of adequate funding is keeping many new cleanup actions from being started and in many cases is forcing ongoing cleanups to be stretched out by years.

On January 7, 2004, the Inspector General released its report of the funding shortfall for FY2003. This report identified a funding shortfall of $174.9 million. It has been widely reported that the funding shortfall for FY2004 reached approximately $250 million.

During the last four years of the Clinton Administration, the Superfund program completed all construction activities at an average of 87 sites per year. In FY2001, however, the Bush Administration completed construction at only 47 sites -- a 46 percent reduction from the average in the last four years of the Clinton Administration. The slowdown will continue in FY2005 and FY2006 since the Administration's budget projects only 40 construction completions each year.

### Brownfields

The Government Accountability Office has estimated that there are 500,000 Brownfields sites across the country that need attention. These sites include abandoned or underutilized warehouses, gas stations, salvage yards, vacant lots, and other lightly contaminated properties. Both the President's budget requests and the Congressionally enacted levels fall far short of the funding needed and authorized by the Small Business Liability Relief and Brownfields Revitalization Act.

The President's budget for FY2006 continues the pattern of the last several years of underfunding the Brownfields grant and loan program. In FY2004, President Bush requested $120.5 million for the Section 104(k) Brownfields grants and $29 million for EPA administrative cost. Similarly, in both FY2005 and this year, the President is seeking $120.5 million for Section 104(k) Brownfields grants plus approximately $30 million in administrative costs. These Presidential budget requests are approximately $50 million less than the authorized amount.

**Safe Drinking Water**

On September 20, 2002, the EPA released a report entitled "The Clean Water and Drinking Water Infrastructure GAP Analysis" which found that for drinking water the funding gap between projected spending, assuming no growth in revenues, was $265 billion for the 20-year period from 2000 to 2019. Assuming a three percent annual real growth in revenues the report indicates that the gap on the drinking water side could possibly be reduced to $53 billion dollars.

The huge funding needs documented in the EPA and CBO reports compares to the $850 million budgeted in FY2005 by the Bush Administration for the state drinking water revolving loan fund. Local governments, states, drinking water suppliers, and the EPA all agree that there is a tremendous resource gap -- which will continue to grow -- for drinking water infrastructure funding necessary to protect the public health. President Bush's FY2006 budget request of $850 million for the state drinking water revolving loan fund freezes this important program with no adjustment for inflation. The funding request is $150 million less than the amount authorized by Congress.

Sincerely,

JOHN D. DINGELL
RANKING MEMBER

Attachments

cc: The Honorable Joe Barton, Chairman
Committee on Energy and Commerce

# Medicaid, Medicare, SCHIP, and Health Tax Proposals
# Budget Highlights
# Fiscal Year 2006 Request

## March 3, 2005

*Analysis prepared by Committee on Energy and Commerce Democratic Staff*

The Bush Administration has started a second term with many of the same failed proposals it advocated in the previous four years. The budget proposals do little to protect existing health insurance coverage or expand coverage to reach more of the uninsured. To the contrary, their health tax policies coupled with Medicaid cuts will cause more Americans to lose their health insurance and join the already 45 million uninsured.

On the Medicaid side, the budget proposes $60 billion in cuts over ten years from changes to state funding rules, administrative payment cuts, prescription drug payment changes, and limiting asset transfers. The Medicaid program serves nearly 50 million Americans, and its numbers have grown in recent years, particularly as the number of poor households went up for the third straight year and the number losing employer-sponsored coverage has increased. In addition, Medicaid is starting to feel the effects of the baby boom generation resulting in more elderly placing demands on the program for uncovered Medicare benefits. Monies saved from funding mechanism changes could immediately be reinvested in the program in order to keep more people from joining the roles of the uninsured, but the budget cuts those funds instead.

With respect to Medicare, the main budget initiatives are minor regulatory proposals to modify existing provider payment policies. Notably absent are any proposals to improve the Medicare drug benefit by allowing the Secretary to negotiate lower drug prices for beneficiaries or filling in the donut hole. The Administration's budget also does not include legislative or administrative proposals to address the pending cuts to Medicare physician payments.

The bulk of the Administration's new spending on health care comes from tax proposals, $125 billion over ten years. Unfortunately, these proposals cover very few previously uninsured for the amount of dollars spent.

Finally, the Administration's FY2006 budget includes a proposal to revise budgetary rules that would have a major effect on the existing health insurance programs and would severely restrict improvements or expansions of critical health entitlement programs like Medicare and Medicaid. The Administration's budget purports to resurrect the "pay-as-you-go" (PAYGO) rules that played an important role in moving the Nation from deficits to surpluses under the Clinton Administration. The PAYGO rules enacted in 1990 required both entitlement expansions or tax cuts to be fully paid for by offsetting entitlement cuts or tax increases.

President Bush's budget would require all entitlement increases to be offset, but only by cuts in other entitlement programs. On the other hand, tax cuts would not have to be paid for. Moreover, savings on the tax side, such as closing abusive corporate tax shelters, could no longer be used to finance entitlement benefit improvements. The result would be a slow strangulation of programs such as Medicare and Medicaid for lower- and middle-class Americans, while tax cuts benefitting the wealthiest Americans would be unconstrained.

# Medicaid

The President's budget talks about "modernizing" Medicaid, but essentially shifts more costs to the states and children, individuals with disabilities, the elderly, and parents. The budget cuts $60 billion out of the program yet only provides $16 billion in new spending on programs -- about $1 billion of which extends programs currently operating for the low income, while most of the remainder of the $16 billion in "spending" is merely an increase in the baseline.

## Medicaid "Reform"/State Flexibility Proposals

The Administration is again proposing to "reform" Medicaid to "expand principles that are employed in SCHIP and emphasize innovation." Few details are provided about what flexibility the Administration seeks to grant. The budget hints at a few changes such as reducing benefits and increasing cost sharing in its references to making Medicaid more like the SCHIP program, using phrases such as "provide appropriate benefits packages" and "incorporate private sector insurance options."

Notably, Medicaid outperforms private insurance in terms of costs. Medicaid costs less than private sector insurance (30 percent less for adults and 10 percent less for children) after adjusting for health differences.[1] Even looking at per capita cost growth, Medicaid has significantly outperformed private insurance over the past four years: Medicaid cost per capita grew at 6.1 percent, while private insurance grew at 12.6 percent.[2] In addition, most private insurance policies do not include substantial long-term care benefits, so a private sector package would be useless to many individuals on Medicaid.

The Administration's proposals to make Medicaid more like SCHIP appear not to consider the differences between the two programs and the populations they serve. As a whole, the SCHIP population is healthier and has more income than the Medicaid population. For example, there are no 85-year-old widows living in nursing facilities or working adults with disabilities receiving SCHIP coverage. While some cost sharing or benefit flexibility might work at higher income levels, it can hurt access to the program at lower levels. For example, according to the Oregon Office of Health

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[1] Hadley and Holahan, *Inquiry*, 2004.

[2] Holahan, John, *Health Affairs*, 2004.

Policy and Research, Oregon Health Plan (Medicaid) enrollment was cut almost in half (from 95,000 to 50,000) within nine months of implementing premium increases. Even under SCHIP, however, there is evidence to show that some cost sharing increases or benefit reductions have adversely affected coverage and access to care as well as increasing non-compliance. In this population, that means either individuals do not get needed care or wind up in the emergency room later where it is more costly.

While the words "block grant" or "funding cap" are absent from the text of the budget documents, Department of Health and Human Services (HHS) Secretary Leavitt has indicated that the Administration still intends to pursue capping federal dollars to states, at least for populations whose coverage under Medicaid is optional. In addition, the budget discusses new flexibility that would allow states to "further increase coverage among low-income individuals and families without creating additional costs for the Federal government."

Caps or block grants would fundamentally alter the Medicaid program, to the detriment of children, parents, the elderly, and individuals with disabilities that it serves. Such mechanisms would shift substantial healthcare costs and risks to the states, and would also create inequities among states. For example, while the national average expenditure on acute care per beneficiary is about $1,200, Nevada spends less than $1,000 while Rhode Island spends close to $3,000.[3] These disparities in spending would become incorporated into any cap proposal, penalizing low-spending states which would be unable to expand and high-spending states that might have a greater number of citizens who are elderly or disabled affecting their costs. If Congress had capped Medicaid spending at the rate of medical inflation in 2000, states would have $87 billion less in federal spending than they do today.[4] Clearly, the coverage and eligibility reductions that occurred during the economic downturn in 2001-03 would have been much worse had a program cap or block grant been in place.

## Medicaid Cuts: $60 billion over 10 years

The President's budget proposes $60 billion of cuts to the Medicaid program over ten years. The budget documents do not back up the estimated savings with significant policy detail or state-by-state analysis on the effect of these cuts, so it is difficult to gauge whether the proposals will actually achieve their stated savings. The proposals, once more details are available, may warrant consideration. But in general, reducing Federal Medicaid funding to states at a time of rising health care and drug costs, increasing numbers of uninsured, and states' increasing difficulties in paying their share of Medicaid costs, is bound to force states to squeeze Medicaid programs in ways that will reduce coverage and increase the numbers of uninsured. Savings realized from less draconian changes to the Medicaid program would help states meet the challenges of rising healthcare costs and increasing Medicaid enrollment. Instead, the approach the President's budget takes weakens the healthcare safety net for many of the Nation's most vulnerable people.

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[3] Urban Institute estimates based on data from CMS (form 64).

[4] Center for Budget and Policy Priorities, 2005.

## "Program Integrity" Cuts

More than a third of the proposed $60 billion in cuts comes from changing current law rules regarding state funding of the Medicaid program through upper payment limit (UPL) rules, intergovernmental transfer (IGT) rules, and provider tax rules. Unfortunately, the budget offers few details and no assessment of how these proposals will affect different states.

**Restricting Intergovernmental Transfers (IGTs) (Savings of $0 in 2006, 4.6 billion over five years, $11.9 billion over 10 years)**

The President's budget proposes to limit intergovernmental transfers which the Administration believes allowed many states to "game" the Medicaid financing structure. Many states rely on IGTs to fund their Medicaid budgets; for example California and New York both require local tax-based contributions to the state's funding of Medicaid. The Administration's IGT proposal would limit states' ability to use local or county government contributions to provide payment for Medicaid, but no other detail is provided. It is unclear how this proposal would affect the currently legal IGTs in states such as New York or California.

**Cost Based Reimbursement for Government Providers (Savings of $0 in 2006, $1.2 billion over five years, $3.3 billion over 10 years)**

Under current law, Medicaid can pay government-owned providers up to the Medicare payment rate which is higher than Medicaid rates (this is known as the upper payment limit or UPL). Some states use these higher provider payments to draw down federal matching dollars, but then the government-owned provider is often required to return extra funds (now supplemented by federal dollars) to the state coffers. This funding is frequently, but not necessarily, either reinvested in the Medicaid program or used for other health care programs. Congress took steps to curb inappropriate schemes most recently in 2000 and 2001. A number of states are still phasing out certain UPL mechanisms as a result of the 2000 law.

As with the IGT proposal, the Administration has provided few details on how this UPL proposal would work. Interestingly, in Medicare, Congress has been moving away from paying providers based on costs. It is not known how the Administration would define a provider's "costs" for this purpose, nor what kind of reporting burden this will place on providers and states to document costs.

**Provider Taxes (Savings of $231 million in 2006; $6.2 billion over 10 years)**

The Medicaid statute currently allows states to tax providers in order to raise revenue for the Medicaid program. To qualify as an allowable tax, the tax must be broad based, uniform, and must not hold the provider harmless (i.e., make the provider whole for the tax paid). If a tax is more than six percent of the providers' total revenues, it is considered to hold that provider harmless.

The President's budget proposes to phase down the amount states could tax health providers as a means of financing the state's share of Medicaid from six percent to three percent. Again, as with the UPL and IGT provisions in the budget, there is no description of which states would be affected and how much money is at stake in each state. Since the six percent requirement is a CMS regulation, not statute, any change could be accomplished without Congressional action.

**Managed Care Provider Tax Changes (Savings of $0 in 2006, $399 million over five years, $1.4 billion over 10 years)**

The Administration believes that managed care organizations (MCOs) in a few states (MI, CA, and PA) are structuring their business so as to avoid the statutory requirement that provider taxes be uniform, essentially exempting the private side of the MCO's business from the tax. The President's budget proposes to stop this practice.

**Medicaid and CHIP Financial Management (Savings of $25 million in 2006)**

The budget provides additional discretionary funding for Federal oversight of states' financial practices within the Medicaid and CHIP programs, presumably to supplement the 100 auditors CMS sent to states last year. The initiative calls for more audits of state Medicaid programs and closer financial management scrutiny. The Administration proposes using $25 million of the Health Care Fraud and Abuse Control funding in 2005 to help finance this initiative.

## Administrative Payment Cuts

More than $17 billion of the $60 billion in cuts comes from changes to administrative payments to states: establishing fixed "administrative claim allotments" ($6 billion), reducing the federal matching rate for targeted case management (TCM) services to 50 percent in all states ($4 billion), and "clarifying" allowable services that can be claimed as TCM ($7.7 billion).

**Administrative Claim Allotments (Savings of $0 in 2006, $1.1 billion over five years, $6.0 billion over 10 years)**

Currently, Medicaid administrative claims are matched by the Federal Government at 50 percent with no cap on expenditures, recognizing that state administrative costs change as their programs change – for example, information technology updates, a significant upturn in the number of applicants requiring more staff, etc. The President's budget proposes to block grant state Medicaid administrative costs, cutting $6 billion in Federal funding out of Medicaid, even though new responsibilities are being placed on states under the President's budget and will likely impose more administrative burdens.

States have the responsibility of finding and enrolling Medicare dual eligibles for the Medicare prescription drug benefit. In addition, the President is asking states (and others in the health system) to aggressively move ahead with improving information technology (IT) as well as disease management programs. The Administration recently proposed regulations to require states to measure improper payment in Medicaid and SCHIP at an estimated cost of more $1 million per state each year. Significant state administrative work is required as well to answer the requests of the Administration's 100 auditors it has placed in state capitals. Under these conditions, it is difficult to see how states will be able to meet their program responsibilities with less funding. Notably, Medicaid administrative costs are considerably lower than that of private insurers despite Medicaid's various administrative responsibilities.

The President's budget is silent on the formula used for allotting federal matching funds for administrative costs among the states under the Administrative Block Grant. Nor does the budget discuss the base year that the formula will use. The Block Grant would penalize efficient states or states that are about to embark on information technology updates or other activities that would require an increase in spending. In addition, it will be important to understand which of the following administrative costs will be subject to fixed allotments:

- Additional administrative costs imposed by MMA for implementation of Part D;
- Outreach and enrollment;
- Improvements to program integrity efforts;
- Improvements in computer systems to improve quality of care, better facilitate electronic medical records, and improve program management;
- Medicaid fraud control units;
- Medicaid management information systems (MMIS);
- Survey and certification of nursing homes and ICFs/MR;
- Immigration status verification;
- External quality review of managed care organizations;
- Quality improvement organizations;
- Claims processing;
- Managed care contracting;
- Drug utilization review;
- Disease management.

**Reducing Federal Funding for Targeted Case Management ($129 million in 2006, $1.0 billion over five years, $4.0 billion over 10 years)**

Other Medicaid Administrative cuts come from lowering the Federal matching rate for targeted case management (TCM) services. The Administration believes these services should be claimed as administrative services, not medical services. Section 1915(g) of the Social Security Act defines case management as services which will assist individuals in gaining access to needed medical, social, educational, and other services. The President's budget proposes to lower the matching rate for TCM services from the state's current matching rate for medical services to 50

percent. This change will affect only those states that have federal matching rates in excess of 50 percent. According to a recent CRS document, Georgia, Texas, Tennessee, and South Carolina would be the four states facing the largest cuts as a result of this proposal.[5]

Target populations receiving case management include children with developmental disabilities, the mentally ill, abused and neglected children in the child welfare system, people with AIDS, etc. In Texas, one of the states that would face the largest funding cut, this proposal would affect services provided to infants and toddlers with developmental disabilities, children in foster care, elderly receiving protective services, mentally retarded individuals and the chronically mentally ill, among others. TCM services are important for those living with disabilities to manage their care in the community. Cutting funding for services that help individuals with disabilities manage their care is inconsistent with the emphasis in the President's budget on assisting individuals with disabilities to move into the community through the New Freedom demonstrations and the stated desire to improve care coordination.

**Limiting Services Covered Under the Targeted Case Management Benefit (Savings of $0 in 2006, $2.0 billion over five years, $7.0 billion over 10 years)**

The budget proposes to "clarify" allowable services that can be claimed under TCM and rehabilitation services, because the Administration believes states are using TCM to inappropriately pay for costs in other programs. In short, some services currently allowable will no longer be eligible for federal matching. The President's budget fails to identify which of those services would be affected nor does it identify how much TCM funding is at stake in each state.

## Prescription Drug Payment Modifications

Another $15 billion of the $60 billion in cuts to Medicaid funding is from a change in the way Medicaid pays for prescription drugs.

**Restructure Pharmacy Reimbursement (Savings of $452 million in 2006, $5.4 billion over five years, $15 billion over 10 years)**

The budget proposes to replace the pharmacy reimbursement formula under Medicaid, which is currently based on average wholesale price (AWP), with average sales price (ASP). According to the Administration, this policy would more closely align pharmacy reimbursement with pharmacy acquisition cost and reduce outlays. The Committee on Energy and Commerce held a hearing on December 7, 2004, exploring these pricing issues and the Congressional Budget Office (CBO) also issued a report on this subject in December of 2004 entitled "Medicaid's Reimbursements to Pharmacies for Prescription Drugs."

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[5]CRS Memo to John D. Rockefeller IV, "Medicaid Targeted Case Management," February 14, 2005.

**Modifying Medicaid Drug Rebate Formula (Budget Neutral)**

The Medicaid drug rebate program requires all drug manufacturers to pay a rebate to states for drugs provided through Medicaid. For brand name drugs, the rebate amount is the greater of either (1) the average manufacturer's price (AMP) minus 15.1 percent or (2) the difference between the AMP and the manufacturer's "best price" for that drug. According to the Administration, the "best price" requirement prohibits manufacturers from negotiating discounts with large non-Medicaid purchasers such as hospitals and HMOs, because otherwise that price would extend to all prescriptions paid by Medicaid. The budget proposes to replace the best price with a "budget neutral" flat rebate amount, which would then allow private purchasers to negotiate lower drug prices. The Administration did not specify what level of "flat rebate" would be required for the proposal to be budget neutral. It is unclear whether this policy would lead to lower drug prices under Medicaid.

## Long Term Care Cuts

**Nursing Home Transfer of Assets (Savings of $99 million in 2006, $1.5 billion over five years, $4.5 billion over 10 years)**

The Administration proposes to limit Medicaid asset transfers to further restrict passing assets from the elderly to their children and other family members in order to qualify for Medicaid. The budget does not provide any additional guidance on exactly what policy is being proposed.

**Partnership for Long Term Care (Budget Neutral)**

Long Term Care Partnership programs have operated in four states (New York, California, Connecticut, and Illinois) since the 1990s. These programs arose out of a joint initiative with the Robert Wood Johnson Foundation to examine whether combining public and private resources would help balance the financing of long-term care. The goal was to see whether by increasing the number of people financing at least part of their care through private insurance, Medicaid expenditures would be reduced. The Partnership allows individuals to purchase long-term care insurance to cover the *initial* cost of long-term care; once the policy runs out, the individual would then be eligible for Medicaid coverage without divesting their assets. The President's budget includes a proposal that would change current law to eliminate the prohibition on developing additional long term care "partnership" programs in other states. This proposal was also included in last year's budget.

While the Partnership program has been running for a number of years, there is little evidence thus far to say whether it has saved Medicaid any money or merely allowed relatively higher income individuals to shelter assets.[6] In addition, the Partnership states have improved long-term care insurance standards somewhat, yet many state insurance markets currently lack these protections. The proposal leaves many unanswered questions. Would standards and market reforms be provided to

[6] Ahlstron, Alexis, Emily Clements, et al, "Long Term Care Partnership Program: Issues and Options," Pew Charitable Trusts, 2004.

ensure that individuals are enrolled in quality long-term care products? Would these products have inflation protection and solvency standards? How long would the individual be required to have coverage before becoming eligible for Medicaid? Could the proposal give Medicaid a long term obligation to extend coverage to people who otherwise would not qualify?

## Medicaid/SCHIP Spending Proposals: $16.5 billion over 10 years

The President's Fiscal Year 2006 budget proposes to spend a total of $16.5 billion over 10 years on coverage initiatives through Medicaid and SCHIP. The largest portion of this spending ($10 billion) is from increasing baseline spending on currently eligible children that the Administration proposes to identify and enroll through their $1 billion "Cover the Kids" outreach campaign. Another $1 billion of that funding is merely to extend current operating programs for another year. The President's budget includes demonstrations to assist individuals with disabilities to remain in or return to the community through the New Freedom initiative.

### Transitional Medical Assistance (TMA) ($560 million in 2006)

The TMA program allows parents who transition from welfare to work to keep their health insurance through Medicaid for up to a year. Under current law, TMA is set to expire in March of 2005. Last year, the Administration proposed to spend $3.24 billion to extend TMA for five years. This year, however, the Administration included only a one-year extension of Transitional Medical Assistance in the budget for fiscal year 2006.[7] Like last year, the FY2006 proposal includes a number of provisions designed to simplify eligibility for enrollment in the program. States will have the option to offer one year of continuous coverage, waive burdensome reporting requirements, and waive other requirements if they already cover children and families up to 185 percent of poverty. The program simplifications, as well as the extension of the TMA program, were originally included in the Clinton Administration budgets.

### Extension of Premium Benefits to Certain Qualified Individuals (QIs) ($230 million in 2006)

The Administration's budget extends the QI program, a block grant that pays Medicare premiums for seniors and those with disabilities with incomes between 120 percent and 135 percent of poverty, for an additional year and continues the federal obligation to pay 100 percent of the costs of the premiums, subject to the annual allotment as under current law. These benefits are set to expire on September 20, 2005, and the Administration would extend this program for one year.

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[7] The Administration's proposal does not appear to include the cost of extending TMA for the remainder of FY2005.

**Refugee Exemption Extension ($40 million in 2006, $145 million for five years, $145 million for 10 years)**

At present, most legal immigrants are not eligible for SSI until they have resided in the country for five years or have obtained citizenship. Refugees and those seeking asylum are exempted from this ban for the first seven years they reside in the United States. Procedural delays and waiting lists, however, have created a situation where seven years may not be enough time for these groups to gain citizenship. The President's budget includes a proposal to extend for one additional year the seven-year exemption for citizenship filing.

**New Freedom Initiative and Institutional Care Demonstrations ($2.9 billion over 10 years)**

The Administration's budget again proposes three demonstration projects to promote at-home care as an alternative to institutionalization for the elderly and individuals with disabilities, including respite services for caregivers of adults with disabilities and children with severe disabilities, and home- and community-based services for children currently residing in psychiatric residential treatment facilities.

**Money Follows the Person (MFP) Demonstration ($0 in 2006, $1.75 billion over five years)**

The "Money follows the Person" demonstration provides a 100 percent federal match to states who move individuals with disabilities into the community. This enhanced match would only last for one year as an incentive for states to take this option.

**Community Alternative to Children's Residential Treatment Facilities ($5 million in 2006, $99 million over five years)**

This proposal would establish demonstration programs that would allow a limited number of states to establish home- and community-based alternatives for children currently receiving services in residential psychiatric treatment facilities and proposals to allow states to provide respite care services for adults and children with severe disabilities.

**Caregivers' Respite for Children and Adults (Children: $1 million in 2006, $23 million over five years, Adults: $7 million in 2006, $134 million over five years)**

The budget proposes two demonstration programs to test the efficacy of respite care to reduce "burn out" of caregivers of disabled adults and children with severe disabilities and avoid institutionalization.

**Spousal Exemption ($17 million in 2006, $102 million over five years, $256 million over 10 years)**

The President's budget proposes to protect the Medicaid coverage of individuals married to disabled individuals participating in a 1916(b) work incentive program. Under current law, the working individual's income sometimes causes their spouse to lose Medicaid coverage, because the working individual's income is added to the spouse's income thus making them ineligible. The budget proposal also allows this spouse to buy in to Medicaid coverage as well.

# State Children's Health Insurance Proposals (SCHIP)

**Cover the Kids Campaign ($718 million in 2006, $5.6 billion over five years, $11.3 billion over 10 years)**

The President proposes to increase coverage of uninsured, low-income children by spending $500 million in 2006 and another $500 million in 2007 on an outreach campaign in Medicaid and SCHIP.[8] While the President's budget estimates the total cost to be $11.3 billion over 10 years, $10.3 billion of that cost represents the estimated increase in baseline spending due to more children receiving coverage through Medicaid and SCHIP; the outreach campaign itself would cost approximately $1 billion.

While well intentioned, this program is likely to be a false promise to uninsured children. Current estimates reveal that more than 80 percent of the Nation's uninsured, low-income children are eligible for either Medicaid or CHIP.[9] Given the current fiscal situation facing the states, however, many either do not have enough CHIP funding in their block grant to cover currently enrolled children or do not have the state funds to pay for any increase in enrollment in either Medicaid or SCHIP. This means that any children identified through this campaign would likely be placed on a waiting list or be subjected to complicated and burdensome administrative procedures to deter enrollment.

States are already making it more difficult for eligible families to enroll in Medicaid and SCHIP. Between April 2003 and July 2004, nearly half of the states took some action to make it more difficult for *eligible* children and families to acquire health coverage. The procedural barriers imposed in Texas, including eliminating 12 month continuous eligibility, post-eligibility waiting periods, and new premiums, caused more than 149,000 children to lose coverage in the first six months of 2004.[10]

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[8]While the Administration has budget authority for $500 million in FY05 and FY06, it only anticipates $200 million in outlays in each of those years.

[9]Kaiser Family Foundation, *Health Coverage for Low Income Children*, September 2004.

[10]Ross, Donna Cohen and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Family Foundation, October 2004.

By proposing simultaneous cuts in Medicaid, this outreach initiative to find more children would effectively come at the expense of the more than 25 million children with even lower incomes than those in SCHIP.

**Special Enrollment Period In Group Market for Medicaid/SCHIP (no cost)**

As in the past two years, the Administration's FY2006 budget would make it easier for Medicaid and SCHIP beneficiaries to enroll in private health insurance, by making eligibility for Medicaid or SCHIP a trigger for requiring the employer to allow for enrollment in private health insurance outside the plan's open season. While the details are sparse, this proposal appears to impose a new burden on employers and health insurance plans. There are no details, however, as to whether states would have to ensure these employer plans have similar protections that Medicaid and SCHIP have for these low-income populations or whether the state would be required to fill in inadequacies in private insurance benefit packages or ensure affordability of coverage.

**SCHIP Reauthorization ($670 million in 2006, $457 million over five years)**

The Administration proposes to reauthorize the SCHIP program, slated to expire at the end of 2006, one year early (2005). Because the baseline already assumes this program continues and does not sunset, there are no additional costs.

The Administration also proposes, along with reauthorization, to shorten the amount of time states have to spend their initial SCHIP allotment from three years to two years. This would most likely cause funds to be redistributed faster, but could also potentially cause states to run out of funds more quickly.

**Vaccines for Children (VFC) Expansion ($140 million in 2006, $700 million over five years, $1.4 billion over 10 years)**

The President's budget proposes to allow under-insured children (in addition to the uninsured) to receive VFC inoculations at state and local health departments.

## Insurance Market Proposals

**Small Business Health Insurance Pools**

The President's budget proposes to allow small businesses to establish Association Health Plans (AHPs). In theory, businesses would pool together to purchase health coverage for workers at lower rates. Studies by both CBO and Mercer have shown AHPs could jeopardize health insurance coverage for millions of Americans by eroding employer-sponsored coverage. In addition, AHPs are envisioned to allow insurance companies to circumvent state consumer protections and eliminate critical health benefits and consumer protections from coverage. While the healthiest may see slight reductions in premiums, many would see premium increases. Increased premium costs, coupled with an erosion of consumer protections, means that many more would be made worse off than they are today.

**"National Marketplace Initiative"**

The President has also proposed an initiative that appears to waive state laws that regulate health insurance in order to lower health insurance costs. Essentially, insurance companies could choose which state to be licensed in, but then sell their product in any of the 50 states. The likely result is that insurance companies would choose to locate in the states with the fewest consumer or financial integrity protections, creating an atmosphere ripe for abuse. This proposal would present problems for consumers living in one state trying to get recourse going through the Insurance Commissioner of another state. Moreover, state legislatures that passed laws to protect their residents would quickly see their work nullified. Insurance companies could circumvent these protections by locating across state lines. Much like AHPs, this proposal would substantially weaken consumer protections (though no specifics are given in the budget).

**State Pooling Funding ($200 million in 2006, $1.7 billion over five years, $4 billion over 10 years)**

The President's FY2006 budget proposes to provide states with $4 billion to help establish "pooling" options for small businesses and individuals. The budget does not specify whether this money is available to subsidize premiums or simply to give money to states to organize a program. Small businesses can already join pools, and state funding has never been the issue.

## Medicare

Medicare spending in FY2006 is estimated to be $394 billion. The President has proposed very few changes to Medicare. There are no proposals to improve the prescription drug benefit (for example filling in the donut), allowing the Secretary to negotiate prices for medicines, fixing problems in the low-income portion of the benefit, or reducing the overpayments to Medicare Advantage plans.

The Administration's FY2006 budget again puts forward the notion that Medicare has a 75-year "unfunded promise" and proposes to combine the two Medicare trust funds into one. This would make Medicare funding appear to look unstable, perhaps setting the stage for large cuts or caps in Medicare.

The Supplemental Medical Insurance (SMI) trust fund has always been, and was intended to be, funded through general revenues and Congress is required to contribute a portion of SMI funding each year out of the general fund. The anticipated General Fund share of SMI funding over the next 75 years is an "unfunded promise" no more than defense spending or any other spending item that comes from the same general fund.

The FY2006 budget proposal includes minor regulatory changes in Medicare payment policy for hospitals, skilled nursing facilities and rehabilitation hospitals that affect the Medicare baseline. The baseline also assumes that the physician cuts occur in 2006 and beyond; there is no policy or regulatory proposal to address this serious matter in any way.

**Hospital Transfer Policy (Savings of $740 million in 2006, $4.7 billion over five years)**[11]

Medicare currently pays hospitals for inpatient services through the (diagnosis related group) DRG payment system, in which hospitals receive a standard payment regardless of the length of stay. The exception is when a patient is transferred to another hospital, and the DRG payment is reduced. The Balanced Budget Act of 1997 applied this 'transfer provision' to 10 of the highest volume DRGs, reducing payments in cases where a hospital prematurely transfers a patient to a post-acute setting such as home health or a skilled nursing facility. CMS proposes to extend the transfer provision to all DRGs, which would reduce payments to hospitals and therefore generate program savings.

**Inpatient Rehabilitation Facilities (Savings of $70 million in 2006, $860 million over five years)**[12]

Inpatient rehabilitation facilities (IRFs) provide rehabilitation services to Medicare beneficiaries and are paid under a separate payment system than acute care hospitals. To receive this special payment, CMS requires IRFs to have 75 percent of their cases classified in a limited number of special categories (e.g., stroke, spinal cord injury, brain injury, etc.) This criterion is commonly referred to as the "75 percent rule." As part of the Omnibus appropriations bill in November 2004, Congress delayed implementation of a CMS final rule that would make adjustments to the 75 percent rule until a study on its impact is completed by the Government Accountability Office (GAO). The GAO report, originally expected in January 2005, is now likely to be issued in March.

The CMS final rule stipulated that 50 percent of patients must have one of 13 medical conditions (the previous 75 percent rule pertained to just 10 conditions) for cost-reporting periods beginning on or after July 1 to June 30, 2005. The percentage will rise to 60 percent the following year, and 65 percent the year after that. For cost-reporting periods starting on or after July 1, 2007, the rule requires that 75 percent of patients must have one of the 13 conditions.

**Skilled Nursing Facilities (SNFs) (Savings of $1.5 billion in 2006, $10.1 billion over five years)**[13]

In 1998, CMS implemented a prospective payment system for SNFs based on Resource Utilization Groups (RUGs) – analogous to the hospital inpatient DRG system, in which SNFs receive a flat-rate payment for one of 44 categories of illness. While SNFs only receive about 10 percent of their reimbursement from Medicare, the cuts were significant enough to spur Congress to enact four temporary fixes to the rates in 1999. Two of these "fixes" expired in October 2002: a four percent across-the board increase for all SNF payments, and a 16.66 percent increase for SNF nursing care). Two additional payment increases (a 20 percent increase for 15 of the 44 RUGs and a 6.7 percent

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[11] Committee on Ways and Means jurisdiction.

[12] Committee on Ways and Means jurisdiction.

[13] Committee on Ways and Means and Committee on Energy and Commerce shared jurisdiction.

increase for 14 other RUGs), total over $1 billion in annual spending, and remain in effect until CMS refines the RUG system. CMS plans to implement RUG refinements this year, and includes these savings assumptions in the FY2006 budget.

In addition to the administrative proposals described below, the budget also outlines an initiative to improve health care quality in Medicare by exploring provider payment reforms that link quality to Medicare reimbursement in a cost-neutral manner. There is no new budget authority associated with this goal. An enhanced role for the Quality Improvement Organizations, however, that review and monitor quality of care delivered by Medicare providers, is reflected in a $24 million increase in funding over the FY2005 level. MedPAC and others have endorsed the "pay-for-quality" concept.

## Health Tax Proposals

The budget contains five tax proposals related to the provision of health care that together cost $44.6 billion over five years and $125.3 billion over 10 years. Two proposals from the 2005 budget do not appear in the 2006 budget – the above-the-line deduction for long-term care insurance and the exemption for home-care providers of family members. There is one new proposal – a refundable credit for small business contributions to employee HSAs. The mainstay of the budget – a refundable tax credit to purchase health insurance – is still there, and while health insurance costs have increased, the President's budget has not increased the value of the credit they are proposing.

**Refundable Tax Credit for the Purchase of Health Insurance ($28.4 billion over five years, $73.9 billion over 10 years)**

This is the fifth year that the President has proposed a capped, income-related refundable tax credit to purchase health insurance. New this year, however, is an option to use 30 percent of the credit to fund an Health Savings Account or HSA (provided the rest of the credit is used to purchase a high-deductible health plan or HDHP).

Under the President's proposal, individuals under age 65 could claim a refundable income tax credit for the purchase of health insurance. Taxpayers are eligible only if they do not participate in a public or employer-provided health plan. The amount of the credit would be $1,000 per adult and $500 per child for up to two children. The maximum credit available to any family would thus be $3,000 and no more than 90 percent of the cost of the plan. The maximum credit would phase out starting at between $15,000 and $25,000 of taxable income, with a full phase-out at $60,000 in annual income.

The tax credit would be available starting January 1, 2006, and, beginning July 1, 2007, available in advance. Eligibility for the advance credit option would be based on the taxpayer's prior year tax return. Those claiming the credit in advance would reduce their premium payment by the amount of the credit and Treasury would reimburse the health insurer for that amount. Eligible health insurance plans would be required to meet minimum coverage standards, including coverage for high medical expenses. In addition to private health plans, individuals could buy insurance through private purchasing groups, state-sponsored insurance purchasing pools, and state high-risk pools.

It is unlikely these credits would enable most of these families to afford coverage. Two-thirds of the uninsured have incomes under 200 percent of the federal poverty line (about $18,000 a year); with competing demands for food and shelter, few can afford health insurance without significant subsidies. In 2004, the average premium for employer coverage was $3,695 per year for an individual, and $9,950 for a family.[14] These rates are generally much less expensive than comparable policies in the individual market. The President's tax credit at its most generous would provide a single person at the poverty level ($9,310 in 2004) with a maximum credit equal to a little more than one-fourth (27 percent) of the premium, thus forcing an individual living in poverty to devote nearly 29 percent of their income to health insurance. In fact, one of the major problems with the health tax credit in the Trade Adjustment Act of 2002 has been that even with a 65 subsidy, families still cannot afford the insurance policies.[15]

Other concerns about such an approach include: lack of market protections to ensure policies include benefits families need such as maternity and mental health coverage; lack of guarantee issue resulting in those who are most in need of insurance being unable to obtain a policy; and lack of pricing protections resulting in policies that are unaffordable even for those with more moderate incomes. Finally, tax credits could result in further erosion of employer- based coverage by causing adverse selection where the healthy will opt out of employer-based insurance leaving the sicker people to drive up employer costs. A study by Jonathan Gruber at MIT found that 1.4 million Americans would lose employer-sponsored coverage and become uninsured if the President's tax credit proposal became law.

**Above-the-line Deduction for High-Deductible Insurance Premiums: ($10.1 billion over five years, $28.5 billion over 10 years)**

Effective in 2006, the Administration's proposal would allow for those without employer-sponsored coverage to take an above-the-line deduction (available regardless of whether a taxpayer itemizes deductions) for premiums for high-deductible health insurance policies. While the individual must have a high deductible policy (a policy that would qualify the individual to have a HSA), the individual does not have to actually maintain an HSA[16]. The minimum deductible for such policies is $1,000 for single and $2,000 for family coverage. The maximum out-of pocket is $5,100 for single and $10,200 for family coverage.

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[14]Kaiser Family Foundation / Health Research and Educational Trust 2004 Employer Health Benefits Survey.

[15]*See* Robert Pear, "Sluggish Start for Offer of Tax Credit for Insurance," *New York Times*, January 24, 2004.

[16]The Medicare prescription drug bill passed in 2003 created Health Savings Accounts (HSAs), which are tax-preferred savings accounts for people who purchase high-deductible health plans. Contributions to these accounts are tax-deductible, earnings on funds in these accounts accrue tax-free, and withdrawals from the account are not taxed if they are used to pay for out-of-pocket medical costs. The HSA rules do not permit tax-free withdrawals from the accounts to be used to pay premium costs for health insurance.

**Refundable Tax Credit for Contributions of Small Employers to Employee HSAs: ($6.1 billion over five years, $22.7 billion over 10 years)**

Small non-governmental, for-profit employers (under 100 employees) could qualify for a refundable tax credit to reimburse the employer for contributions made to employee Health Savings Accounts (HSAs). The maximum credit per employee would be $200 for single coverage and $500 for family coverage. To qualify for the credit, the employer would have to maintain a high-deductible health plan available to all employees but would not have to pay any part of the premium. The employer contribution that is reimbursed through the credit would only be available for medical expenses. A 100 percent tax would apply to any withdrawal in excess of qualified medical expenses.

**Trade Adjustment Assistance Reform Act of 2002 (TAA) Tax Credit ($68 million over five years, $179 million over 10 years)**

The Trade Adjustment Assistance Reform Act of 2002 provides a health tax credit to those who lose their jobs because of trade. Individuals eligible for TAA benefits and those between the ages of 55 and 64 receiving benefits from the Pension Benefit Guaranty Corporation are eligible for the refundable, 65 percent credit. (PBGC is a federal corporation created by the 1974 ERISA law to encourage the continuation and maintenance of defined benefit pension plans. PBGC protects the pensions of about 44 million workers and retirees nationwide.) The credit can be claimed on the income tax return at the end of the year, or paid in advance by the IRS each month directly to the health plan. The Administration proposes some noncontroversial technical changes to the TAA tax credit, except for one that would allow insurers to apply a 12-month pre-existing condition exclusion to recipients (under current law, no pre-existing condition exclusion is allowed for TAA policies). In general, however, the changes are likely to allow greater use of the credit, which is why there is a cost.

# Public Health
# Budget Highlights
# Fiscal Year 2006 Request

## March 3, 2005

*Analysis prepared by Committee on Energy and Commerce Democratic Staff*

The public health portions of the budget have come under significant criticism. For example, under the President's plan the CDC budget would be reduced by $550 million. While the Nation's top three causes of death are chronic diseases -- heart disease, cancer, and stroke -- the President proposes cuts in CDC's chronic disease prevention and health promotion program of 6.5 percent, or $60 million. Reductions include programs aimed at fighting childhood obesity, trauma care, health professions training, food and drug safety, disease prevention, and substance abuse prevention. The American Public Health Association (APHA) has said these cuts are emblematic of the Administration's shortsighted approach to public health in general.

The budget also includes a 64 percent cut to a program for training nurses, dentists, and other health professionals through the Health Resources and Services Administration and a proposal to cut bioterrorism preparedness funding 12.6 percent. According to APHA's Executive Director, "There is no doubt that the bioterrorism funding of the last few years has strengthened the nation's preparedness capability and our ability to deliver public health services. But after suffering decades of neglect, cuts will jeopardize the initial progress we made. Funding must be sustained to rebuild our public health system and to better protect Americans."

Similarly, the Association of State and Territorial Health Officials (ASTHO) has said that the proposed cuts in the Administration's FY2006 budget "would weaken the ability of state and local public health to respond to bioterrorism, emerging infectious diseases, or other public health threats and emergencies." ASTHO expressed concern with proposed cuts in funding to the CDC and the Health Resources and Services Administration for state and local public health preparedness at the same time that public health agencies are being asked to expand their role in disease surveillance, food safety and security, related mental health issues, and the distribution of Strategic National Stockpile pharmaceuticals.

Specifically, ASTHO points out that the budget calls for elimination of the Preventive Health and Health Services Block Grant, which provides $131 million to the states to meet unanticipated public health emergencies, such as have been encountered with West Nile virus, E. coli outbreaks, and SARS, or to implement prevention programs against injury, heart attack, stroke, and other chronic diseases. ASTHO also expressed concern with "insufficient funds to cover the rising costs of vaccines for underserved children and adults and to develop the necessary infrastructure to support adult immunization programs, such as those needed to address any new pandemic influenza outbreak."

According to ASTHO "Federal funds have been pivotal in helping state public health agencies improve their response capabilities . . . . Previous budgets have supported our efforts to rebuild a system that has suffered more than two decades of neglect. We have serious concerns that reductions in public health funding are being proposed at a time when we truly need a sustained federal commitment to our nation's public health . . . . Strong support for enhanced immunization programs, terrorism response planning, and chronic disease prevention is critical to the states' abilities to protect the nation's health."

The full text of the APHA and ASTHO statements with respect to the FY2006 budget are on their respective Web sites. Citations to these as comments of other public health advocates are found at the end of this memorandum.

The Administration's budget continues a pattern of "interagency transfers" of funds, which makes it difficult to analyze the true level of support for certain programs. For example, the entire budget of the Agency for Healthcare Research and Quality (AHRQ) is funded by a transfer of funds from the National Institutes of Health (NIH). The full extent of such interagency transfers is not known at this time.

**Agency for Healthcare Research and Quality**

One of the major concerns with the AHRQ budget is the level of support for the comparative effectiveness research program that was specifically authorized in the Medicare Modernization Act. The $15 million requested falls far below the level that some view as adequate for realization of this program's potential. The AHRQ budget also includes part of the Administration's health information technology (IT) program. The aggregate health IT level of effort in the budget again falls far short of what some consider adequate. Health IT holds the promise for increasing health quality by reducing medical errors, and for decreasing health care costs.

**Centers for Disease Control and Prevention**

As has already been noted, the FY2006 budget proposal for the CDC calls for elimination of the Preventive Health and Health Services block grant. The Administration contends the block grant duplicates and overlaps other CDC programs. Major state and local public health organizations do not agree. CDC's chronic disease prevention and health promotion budget would be cut significantly under the Administration's proposal. The justification for this cut is that a specific media campaign aimed at childhood obesity is a demonstration whose time has expired, but the health community would disagree. The Administration does not propose any new programs to fight obesity. Finally, the CDC budget proposes cuts in programs for funding bioterrorism preparedness.

**Food and Drug Administration**

The Administration points to some modest increases in some post market safety programs. Whether a particular function is slated for a modest increase, freeze, or cut, as a whole the proposed budget for FDA does not allay concerns over the adequacy of FDA's resources to support its capacity to do more safety data collection for products such as drugs, devices, food, and dietary supplements. Devotion of adequate resources to this function would help reduce adverse events and would assist consumers with making more informed choices for themselves and their families.

An article that appeared in USA Today on February 15, 2005, highlights some of the key concerns with the proposed budget for FDA. According to Julie Appleby:

> "The Food and Drug Administration's proposed budget for next year includes cuts to nearly all its inspection programs, from checks on imported food to reviews of overseas plants that make prescription drugs bound for the USA. If Congress approves, the number of domestic food safety inspections made next year would fall by 5%, foreign drug plant inspections would drop 5.8% and checks on the nation's blood banks would be cut 4.7%, compared with estimated 2005 inspections.
>
> "The reductions are included in a $1.9 billion budget that gives the agency an overall 4.5% increase. Increases are earmarked for several projects, including expansion of a network of labs to analyze food for bioterror agents and increasing staffing in the office that monitors the safety of prescription drugs once they hit the market.
>
> "The proposed cuts come amid criticism the FDA failed to inspect often enough a long-troubled British vaccine plant that the United States had counted on for half of its flu vaccine supply. All the plant's vaccine was impounded last year after British regulators discovered serious problems, which were later confirmed by the FDA.
>
> "Some experts fear reducing inspections could make the USA more vulnerable to counterfeit drugs or improperly made products. 'We don't want to end up with a buyer-beware market for necessary medicines,' says Sarah Sellers, an FDA adviser, pharmacist and drug-safety expert. In a statement, the FDA said it is targeting inspections where risks are highest: 'Intelligent, risk-basked inspections are more important than absolute numbers of inspections. (The agency) is committed to carrying out our mandate of promoting and protecting the public health.
>
> "Responding to ongoing criticism of the FDA's role in the vaccine problems this year, a top FDA official last week told Congress the agency will begin inspecting vaccine plants once a year, rather than the once every two years that is required.

"Still, the number of drug plant manufacturing inspections would drop from 1,430 this year to 1,355 next year. The number of foreign drug inspections would fall from 515 to 485. The FDA also inspects companies that process human tissue for medical uses and companies that produce cheese, fish, juice and other foods."

**Health Resources and Services Administration**

The Administration increased funding for the Ryan White CARE Act, but, even with these modest increases, many contend there will still be a significant gap between the resources that are needed and those that are provided for prevention and treatment of HIV/AIDS.

The budget calls for zero funding for the health professions programs. It also proposes elimination of programs dealing with traumatic brain injury, emergency medical services for children, and the highly acclaimed Healthy Community Access Program. The budget says these programs are "underperforming." Again, rather than propose new programs to address the important public health issues in these areas, the administration simply eliminates all support for any programs. Rural health programs are also cut.

**National Institutes of Health**

The Association of American Medical Colleges states that it is "deeply disappointed that the President's 2006 proposal is a rerun of last year's budget with insufficient federal support for medical research. Specifically, the President's recommended increase of 0.7 percent for the National Institutes of Health for the third year in a row is well below the rate of inflation and is woefully inadequate to sustain the promising pace of medical research. If this funding trend continues, America's position as the world leader in research will be threatened." Other stakeholders with expertise to assess this part of the budget have expressed similar concerns. The Administration's budget documents concede that less research will be funded.

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

The budget requests a substantial cut, $56 million, in resources that go to SAMHSA. The budget acknowledges that the Substance Abuse Prevention and Treatment Block Grant "is the cornerstone of States' substance abuse financing, accounting for at least 40 percent of public funds expended for prevention and treatment." Programs of regional and national significance for substance abuse prevention would be cut. This program would get no new money under the budget, which constitutes a cut in resources available for this program. Mental health programs would see a decrease of $64 million under the budget.

# Quotes from Statements by Various Public Health Advocates regarding the FY2006 Budget

"Cuts to the Centers for Disease Control and Prevention are emblematic of the administration's shortsighted approach. Under the president's plan the agency loses $550 million. While the nation's top three causes of death are chronic diseases - heart disease, cancer and stroke, the president cuts CDC's chronic disease prevention and health promotion program by 6.5 percent, or $60 million. . . ."
*-- American Public Health Association (APHA)*

➜ **To read the APHA's full statement see their Web site:**

**http://www.apha.org/news/press/2005/2005_budget.htm**

"Cuts in the Administration's proposed FY06 budget would weaken the ability of state and local public health to respond to bioterrorism, emerging infectious diseases, or other public health threats and emergencies . . ." *-- Association of State and Territorial Health Officials (ASTHO)*

➜ **To read the ASTHO's full statement see their Web site:**

**http:://www.astho.org/templates/display_pub.php?u=JnB1Yl9pZD0xMzQ5**

"The AAMC is also deeply disappointed that the president's 2006 proposal is a rerun of last year's budget with insufficient federal support for medical research. Specifically, the President's recommended increase of 0.7 percent for the National Institutes of Health for the third year in a row is well below the rate of inflation and is woefully inadequate to sustain the promising pace of medical research. If this funding trend continues, America's position as the world leader in research will be threatened."
*-- Association of American Medical Colleges (AAMC)*

➜ **To read the AAMC's full statement see their Web site:**

**http://www.aamc.org/newsroom/pressrel/2005/050208.htm**

"The American Nurses Association (ANA) today expressed its disappointment with the funding levels for programs to enhance the recruitment and retention of nurses in President Bush's proposed fiscal year (FY) 2006 budget. The President's budget was submitted to Congress on Feb. 7."
*-- American Nurses Association (ANA)*

➜ **To read the ANA's full statement see their Web site:**

**http://www.nursingworld.org/pressrel/2005/pr0208.htm**

"Taken together, the inadequate FY06 investments in research proposed by the Administration would erode the research and innovative capacity of our nation."
*-- Association of American Universities (AAU)*

➜ **To read the AAU's full statement see their Web site:**

**www.aau.edu/budget/06statement.pdf**

"The American Diabetes Association is deeply disappointed by President Bush's proposed federal budget cuts to agencies responsible for responding to the diabetes epidemic facing this country. There are currently 18.2 million Americans living with diabetes . . ."
*-- American Diabetes Association (ADA)*

➜ **To read the ADA's full statement see their Web site:**

**http://www.diabetes.org/diabetesnewsarticle.jsp?storyId=7989995&filename=20050207/comtex20050207pr00004528vadiabetesbudgetEDIT.xml**

"President Bush's FY 2006 budget will again shortchange Americans' health as we battle against our nation's most deadly and costly health threats - heart disease, stroke and other cardiovascular diseases, according to the American Heart Association. The proposed new budget calls for less than a 1 percent increase next fiscal year for the National Institutes of Health (NIH), and a 7 percent cut for Centers for Disease Control and Prevention (CDC) programs, including those aimed at heart disease and stroke prevention." *-- American Heart Association (AHA)*

➜ **To read the AHA's full statement see their Web site:**

**http://www.americanheart.org/presenter.jhtml?identifier=3028759**

# Environment
# Budget Highlights
# Fy2006 Request

## March 3, 2005

*Analysis prepared by Committee on Energy and Commerce Democratic Staff*

## Superfund Program

The President's FY2006 budget request for the Superfund program is a reduction of $102 million from his budget request last year. In FY2005, the President sought $1,381,416,000 for the Superfund program. In this year's FY2006 budget, the President is requesting $1,279,333,000 for the Superfund program.

The request fails to provide any justification for a reduction at a time when the lack of adequate funding is already keeping many new cleanup actions from being started and in many cases is forcing ongoing cleanups to be stretched out by years. On December 2, 2004, Assistant Administrator Thomas Dunne, the top Superfund program official, commented publicly in a speech at the University of Virginia on the effects of the funding shortfall:

> "For the last three years, we haven't started cleanup at some new sites. If we assume that EPA's budget will remain flat for the foreseeable future, construction funding could be delayed at more and more sites. Within a few years, unfunded cleanup work could total several hundred million dollars."

This trend is clear and it comes at the expense of public health and the environment and economic redevelopment in our local communities. In June 2002, the Environmental Protection Agency (EPA) Inspector General reported a funding shortfall of $225 million that was slowing the cleanup of the Nation's most toxic waste sites listed on the Superfund National Priorities List (NPL). Thirty-three sites in 19 states were being adversely affected. The Agency then scrambled to de-obligate and re-certify unexpended prior year funds. On October 25, 2002, the Inspector General reported the final funding shortfall for FY2002 with respect to remedial actions and long-term remedial action responses. The Inspector General concluded that ongoing cleanups at five sites were inadequately funded in the amount of $23 million. An additional seven sites received no funding at all and the shortfall amounted to $91.8 million. The total shortfall for FY2002 was thus $114.8 million.

On January 7, 2004, the Inspector General released its report of the funding shortfall for FY2003. This report identified a funding shortfall of $174.9 million dollars which was dramatically slowing the pace of cleanup at 29 sites in 17 states. In addition, internal EPA documents released by the Inspector General showed the financial stress that was confronting all aspects of the cleanup program. Shortfalls in funding were documented in (1) new start

The Inspector General observed the following:

> "When funding is not sufficient, construction at National Priority List (NPL) sites cannot begin; cleanups are performed in less than an optimal manner; and/or activities are stretched over longer periods of time. As a result, total project costs may increase and actions needed to fully address the human health and environment risk posed by the contaminants are delayed."

It has been widely reported that the funding shortfall for FY2004 reached approximately $250 million.

These funding shortfalls are a significant cause in the dramatically reduced number of Superfund sites that have completed construction during President Bush's Administration.

During the last four years of the Clinton Administration, the Superfund program completed all construction activities at an average of 87 sites per year. The Bush FY2002 and FY2003 budgets called this "dramatic progress." In FY2001, however, the Bush Administration completed construction at only 47 sites -- a 46 percent reduction from the average in the last four years of the Clinton Administration and a 39 percent shortfall in the Agency's goal for FY2001.

The slowdown of Superfund cleanups has continued. The EPA attained 42 construction completions in FY2002, 40 construction completions in FY2003, and 40 construction completions FY2004. The slowdown will continue in FY2005 and FY2006 since the Administration's budget projects only 40 construction completions each year.

**Brownfields**

On January 11, 2002, President Bush signed the Small Business Liability Relief and Brownfields Revitalization Act (P.L. 107-118). The Brownfields Revitalization Act placed a legislative framework around the Environmental Protection Agency Brownfields program which was initiated in the mid-1990s during the Clinton Administration.

The Brownfields Revitalization Act added a new Section 104(k) to the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (Superfund) to provide explicit authorization for Brownfields funding. For each fiscal year from 2002 through 2006, the law authorized $200,000,000 to be appropriated for Brownfields grants for site assessment, remediation, and revolving loan funds. The eligible recipients of these grants are the following entities:

- Local governments
- Land clearance authority operating under supervision and control of local government
- Government entity created by state legislature
- Regional councils or group of general purpose units of local government
- Redevelopment agency sanctioned by a state

- States
- Indian tribes
- Alaska Native Regional Corporation
- Non-Profit organizations for remediation grants

The EPA Brownfields program has been significantly underfunded by the President's budget requests and further cut in the actual appropriations provided by the Congress.

In FY2004 only about one in three Brownfields proposals received Section 104(k) Brownfields grants for site assessment, remediation, or revolving loan funds. In a letter to Members of Congress dated June 22, 2004, the U.S. Conference of Mayors, the National Association of Development Organizations, the National Association of Industrial and Office Properties, and seven other organizations called for full funding of the EPA Brownfields grant program and stated the following:

> "Still, EPA has been forced to turn away more than two-thirds of the applicants for federal Brownfields assessment and cleanup funding due to limited funds. As a result, hundreds of thousands of sites remain idle, blighting neighborhoods and undermining local revitalization."

The Government Accountability Office has estimated there are 500,000 Brownfields sites across the country that need attention. These sites include abandoned or underutilized warehouses, gas stations, salvage yards, vacant lots, and other lightly contaminated properties.

The EPA's press release of June 15, 2004, stated that 219 applicants were selected to receive 265 grants for a total grant expenditure of $75.4 million. The press release, however, neglected to mention that there were 755 grant proposals in FY2004 from 504 applicants. Thus, 285 local governments or other applicants applied for a Section 104(k) Brownfields grant representing 490 projects that were not funded.

Both the President's budget requests and the Congressionally enacted levels fall far short of the funding needed and authorized by the Small Business Liability Relief and Brownfields Revitalization Act.

While the Conference of Mayors praised the effectiveness of previous Brownfields grants in leveraging billions of cleanup and redevelopment monies, it stated that the Administration's FY2005 budget request "dramatically underfunds the most important and effective component of EPA's Brownfields program -- the grants to localities and non-profit organizations for site assessments and cleanup."

The President's budget for FY2006 continues the pattern of the last several years of underfunding the Brownfields grant and loan program. In FY2004, President Bush requested $120.5 million for the Section 104(k) Brownfields grants and $29 million for EPA administrative cost. Similarly, in both FY2005 and this year, the President is seeking $120.5 million for Section 104(k) Brownfields grants plus approximately $30 million in administrative costs. These Presidential budget requests are approximately $50 million less than the authorized amount.

These inadequate funding requests were slashed 23 percent by Congress in FY2004 to $92.9 million for Section 104(k) grants and $24.9 million in administrative costs. For FY2005, Congress cut the Brownfields grant appropriation even further to $89.3 million and $24.8 million for administrative costs -- a reduction of 24 percent from the President's budget request.

**Safe Drinking Water**

Public water systems must invest in infrastructure improvements to ensure that they can deliver safe drinking water to consumers. In February 2001, the EPA released the results of a comprehensive survey of our Nation's infrastructure needs. The key finding of the survey is that "$102.5 billion is needed now to ensure the continued provision of safe drinking water" and a total of $150.9 billion over the next 20 years. The EPA budget justification for FY2003 explicitly recognized the large gap between the budget request and the needs of our public water system as follows:

> "According to the Agency's 2001 Drinking Water Infrastructure Needs Survey, the total 20-year national infrastructure needed is $150.9 billion, $31.2 billion of which is needed to ensure the provision of safe drinking water under existing and recently proposed regulations. The need is even more pressing in the face of the projected increases of population growth and the subsequent increase in demand for safe drinking water over the next several decades."

Since the submission of the FY2003 budget, two additional reports have supported the need for tens of billions of dollars of additional drinking water infrastructure funding.

In April 2002, the Congressional Budget Office (CBO) testified before the Subcommittee on Environment and Hazardous Materials that their mid-point estimate of the gap between what public water systems are now spending and what needs to be spent annually over the next 20 years is $4 billion a year or $80 billion over 20 years. This testimony was reaffirmed in a CBO Report issued May 24, 2002, entitled "Future Investment in Drinking Water and Wastewater Infrastructure."

On September 20, 2002, the EPA released a report entitled "The Clean Water and Drinking Water Infrastructure GAP Analysis" which found that for drinking water the funding gap between projected spending, assuming no growth in revenues, was $265 billion for the 20-year period from 2000 to 2019. Assuming a three percent annual real growth in revenues the report indicates that the gap on the drinking water side could possibly be reduced to $53 billion dollars.

The huge funding needs documented in the EPA and CBO reports compares to the $850 million budgeted in FY2006 by the Bush Administration for the state drinking water revolving loan fund. Local governments, states, drinking water suppliers, and the EPA all agree that there is a tremendous resource gap – which will continue to grow – for drinking water infrastructure funding necessary to protect the public health. President Bush's FY2006 budget request of $850 million for the state drinking water revolving loan fund freezes this important program with no

adjustment for inflation. The request is $150 million less than the amount authorized by the Safe Drinking Water Act Amendments of 1996.