ONE HUNDRED TENTH CONGRESS

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

JOHN D. DINGELL, MICHIGAN
CHAIRMAN

March 1, 2007

The Honorable John M. Spratt, Jr.
Chairman
Committee on the Budget
207 Cannon House Office Building
Washington, DC 20515

The Honorable Paul Ryan
Ranking Member
Committee on the Budget
309 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Spratt and Ranking Member Ryan:

Pursuant to clause 4(f) of Rule X of the rules of the House of Representatives and section 301(d) of the Congressional Budget Act of 1974, as amended, the Committee on Energy and Commerce is submitting Views and Estimates on the President's Fiscal Year 2008 budget. It is the custom of this Committee for the Majority and the Minority to transmit separate Views and Estimates. These are the views and estimates of the Majority.

The President's budget for FY2008 continues the trend of this Administration's budgets of the past five 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. The common theme of this budget is its continued insistence upon further tax cuts for the wealthiest Americans while cutting programs critical to working families, seniors, and those most in need.

In the case of the healthcare budget, the President makes significant cuts in critical health insurance programs. The budget makes legislative and regulatory proposals that cut approximately $26.5 billion from Medicaid over five years. In addition, the President proposes legislative changes that cut $66 billion from the Medicare fee-for-service program over five years for a total of $252 billion in Medicare budget cuts over 10 years. The President proposes another $10 billion in regulatory cuts to Medicare over five years, for a total cut over five years of $76

billion. At the same time, the President proposes allocating $139 billion over five years for tax cuts related to Health Savings Accounts, a program that primarily benefits higher-income individuals, and other health tax proposals that weaken employer-based health insurance, and do relatively little to help the uninsured.

In addition, budget process changes sought in the President's Budget would make it considerably more difficult to make positive improvements to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP). The President's FY2008 budget would require any additional spending in these programs to be offset only by cuts in other entitlement programs. The President's budget also cuts many popular and vital public health programs. For example, under the President's plan the budget for the Centers for Disease Control and Prevention (CDC) would be reduced by at least $179 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 programs of $34 million and elimination of almost $100 million in preventive health and health services grants. Other cuts include proposed reductions of $67 million in substance abuse and treatment programs.

With regard to energy, the President's budget prioritizes hypothetical future issues ahead of pressing current ones. For example, it focuses major new resources to counter the potential threat of a future disruption of oil markets, but cuts resources sharply for programs that are helping Americans deal with the after-effects of the dramatic oil market price shocks of 2006.

The President proposes to double the amount of oil in the Strategic Petroleum Reserve, an action that may eventually cost $40 billion at today's oil prices, and to spend $168 million to expand the reserve's capacity. Secretary Bodman has also announced plans to spend $500 million for crude oil purchases this year, saying on February 20, 2007, that "We have enough cash to start the process." In light of the Energy Information Administration's projections of a significant decline in oil prices over near-term years (until about 2015), this approach appears to contradict Congress's directive in the Energy Policy Act of 2005 (EPAct) that acquisitions for the reserve avoid excessive cost to the Government or affecting the price of petroleum products to the consumer.

At the same time, the proposed budget would cut funding for the Low-Income Home Energy Assistance Program, a program that helps the poorest American families to afford their newly higher-cost heating fuel, to $1.78 billion for 2008, 44 percent less than the $3.16 billion available in 2006. It would also cut the Weatherization Assistance Program and State energy efficiency programs by 35 percent, from $318 million in 2006 to $205 million in 2008. These programs provide grants to improve the energy efficiency of low-income housing, a way of coping with energy price increases that helps Americans now, not merely in the event of a future disruption.

President Bush put great weight on new energy technologies in his State of the Union message, calling them "the way forward" in diversifying from oil, and indicating that they would "help us to confront the serious challenge of global climate change." The budget priorities that he has proposed, however, wholly ignore some promising clean nearer-term technologies and offer the bulk of support to technologies very early in gestation. The President would eliminate all funding for new geothermal, hydroelectric, and distributed energy technologies, and would cut funding 21 percent for industrial energy technologies. Research and Development (R&D) on our electric transmission and distribution grid issues is cut 28 percent in the face of a widely recognized need for increased capacity and upgraded technology to optimize existing resources. Wind and solar research budget requests for 2008 are significantly below those made in 2007, and represent small increases over the 2006 budget of $1 million and $65 million, respectively. More favored are clean coal technologies, which could potentially allow us to use our most abundant domestic fuel in a manner consistent with the need to prevent climate change, but which receive a net increase of only $15 million outside the FutureGen program, which is proposed to double its funding to a total of $108 million, and will require years before proof of its concepts. Biomass and biorefinery systems R&D would also be effectively doubled to a total of $179 million. Meanwhile nuclear energy research and development would receive a net increase of $375 million, almost doubling total expenditures, although new reactor designs are many years from operating.

Similarly, in the environment, the budget reflects the impact of domestic spending caps in order to provide for large tax cuts. In one such example, the President has requested just $89.1 million for Brownfields cleanups and assessment grants. The request reflects a 26 percent reduction from the FY2006 budget request, and just 56 percent of the amount authorized in the Small Business Liability Relief and Brownfields Revitalization Act. At the time of its signing, the President described the bill as "a good jobs creation bill." Similarly, the President proposes to cut grants to States and local air quality management by 15 percent of the amount enacted last year.

Areas of particular concern and a more detailed analysis prepared by the Committee majority staff are attached. If you have any questions, please contact me or have your staff contact Yvette Fontenot with the Committee on Energy and Commerce staff at ext. 5-2927.

With every good wish.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

Views and Estimates on the President's Budget For Fiscal Year 2008
Analysis

HEALTH

MEDICAID

The Medicaid program provides health insurance coverage for close to 60 million Americans[1]. Even though the Deficit Reduction Act enacted one year ago cut $28 billion over 10 years[2] from Medicaid, the Administration again is proposing significant cuts to this program once again. The President's FY2008 budget proposes legislative measures that cut Medicaid by $13.7 billion over five years. The President's budget, however, also proposes a number of regulatory changes in Medicaid that cut another $12.7 billion from Federal Medicaid payments over five years that result in a total savings of $26.5 over five years. The budget proposes $5.6 billion in Medicaid spending initiatives for a net legislative and regulatory loss of about $25.6 billion over five years.

Medicaid Legislative Proposals (-$13 billion/5 years)

Many of the legislative cuts are directly attributable to shifting costs from the Federal Government to the States. A number of these changes will also restrict access to services, such as targeted case management or school-based health care for beneficiaries with disabilities.

Reduction in Medicaid Administrative Payments (-$5.3 billion/5 years)
The President's FY 08 proposal would reduce federal spending on all Medicaid administrative activities to 50%, including Medicaid Management Information System (MMIS) used to process claims, utilization review, and systems review. Those activities are currently reimbursed at 90%, 75% and 75% respectively. At a time when the Administration is asking providers and states to move forward with information technology activities to improve health care, it is inconsistent to simultaneously cut funding for those very activities. Moreover, other proposals in the President's budget would reduce states' funding for failing to meet improper claims recovery targets, which becomes increasingly more difficult if this proposal to reduce funding on those activities is implemented.

Elimination of State Flexibility on Home Equity Limits (-$430 million/5 years)
The FY 08 budget proposes to eliminate state flexibility in determining home equity levels for the purposes of qualifying for Medicaid long term care assistance. The Deficit Reduction Act for the first time required states to count the value of a person's home as an asset when applying for Medicaid long-term care assistance. Previously, the home was

---

[1] "The Medicaid Program at a Glance," Kaiser Commission on Key Facts, Kaiser Family Foundation. 1/2005 [http://www.kff.org/Medicaid/upload/the-medicaid-program-at-a-glance-fact sheet.pdf.]
[2] Congressional Budget Office Cost Estimate, S. 1932 Deficit Reduction Act, January 27, 2006.

protected. States were given the option to set the home equity limit at either $500,000 or $750,000. The Administration proposes to eliminate that state flexibility, requiring states to count all homes over $500,000 as an asset. This particularly penalizes those who live in areas where housing prices have skyrocketed.

Reduction in Federal Payments for Targeted Case Management (-$1.2 billion/5 years). The President's budget proposes cutting $1.2 billion over five years by reducing Federal payments for targeted case management (TCM)[3]. These cuts come on top of cuts of $760 million over five years ($2.1 billion over 10 years) to targeted case management in the Deficit Reduction Act[4].

Section 1915(g) of the Social Security Act defines case management as services that assist individuals in gaining access to needed medical, social, educational, and other services. TCM involves assessment and facilitation of meeting service needs, not the provision of the services itself. The Administration believes these services should be claimed as administrative services, not medical services. The President's budget proposes to lower the Federal matching payment rate for TCM services from the State's current payment matching rate for medical services (60 percent on average) to 50 percent. This change will affect only those States that have Federal matching rates in excess of 50 percent. Targeted populations receiving case management services include children with developmental disabilities, the mentally ill, abused and neglected children in the child welfare system, people with AIDS, and foster children. TCM services are important for those living with disabilities to manage their care in the community and these services can eliminate or reduce the need for more intensive or expensive Medicaid services needed in the future[5].

Remove Best Price and Replace with a Flat Rebate (budget neutral). The Medicaid drug rebate program, under current law, 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[6]. 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 become the "best price" and extend to all prescriptions paid by Medicaid. The President's 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, but eliminating the best price without a corresponding increase in the minimum rebate would provide a substantial windfall to drug manufacturers. It is unclear whether this policy would lead

[3] President's Budget for Fiscal Year 2007 Summary table S-6.
[4] Congressional Budget Office Cost Estimate, S. 1932, Deficit Reduction Act, January 27, 2006.
[5] Child Welfare League of America, Targeted Case Management for the Child Welfare Population, July 2005.
[6] Section 1927 of the Social Security Act.

to lower drug prices under Medicaid but it is clear that this policy is intended to allow private payors to receive a better price on prescription drugs than the Medicaid program. This proposal was also included in the President's FY2007 budget.

Restructure Medicaid Prescription Drug Reimbursement (-$1.2billion/5 years).
The President's budget proposes to limit payments for multiple-source drugs to 150 percent of the average manufacturers' price. This would save $160 million in 2008 and $1.2 billion over five years.

Allowing States to Further Restrict Formularies (-$870 million/5 years).
The Administration proposes allowing States to make additional restrictions to prescription drug formularies under Medicaid by allowing the use of "managed formularies." The Administration's budget submission provides no guidance on what this proposal entails but under current law, Medicaid is required to cover all drugs, though States may establish preferred drug lists or require prior authorization before a drug is dispensed[7]. More restrictive formularies, such as those permitted in private insurance, could apply additional barriers to accessing needed medications that will make it more difficult for low-income individuals to obtain their prescriptions. Examples of such policies include prior authorization requirements, step therapy where an individual is required to take one drug and fail before another is permitted, therapeutic interchange between drugs and tiered cost-sharing for different prescription drugs.

This could be particularly burdensome for chronically ill, low-income beneficiaries who generally have numerous prescriptions to take. The recently enacted budget reconciliation spending legislation allowed States to set a preferred drug list and charge significantly more for all but the "least costly" non-preferred drugs and cut Medicaid by $960 million over five years and $5.4 billion over 10 years by permitting States to charge significantly higher cost-sharing for non-preferred drugs for all beneficiaries including children. The Congressional Budget Office estimated that 20 million beneficiaries will face higher cost-sharing for prescription drugs under the Reconciliation spending cuts law by 2015[8]. The President's proposal in the FY2008 budget would allow new and additional barriers to those recently established in the reconciliation spending Act, making it even harder for those with illnesses to access needed medicines.

Reduction of Medicaid Payments for Administrative Costs (Cost Allocation) (-$1.8 billion/5 years).
The Administration believes that Medicaid is inappropriately paying for certain costs under the Temporary Assistance for Needy Families (TANF) program and thus proposes to reduce Medicaid administrative funding to reflect costs covered by TANF, saving $1.8 billion over five years. Medicaid administrative payments fund a variety of important activities such as nursing home survey and certification, quality inspections, and other items that could be jeopardized in States as a result of this proposal. States will become

[7] Section 1927 of the Social Security Act.
[8] Congressional Budget Office Cost Estimate, S. 1932, Deficit Reduction Act, January 27, 2006.

fully responsible for any costs that are excluded as a result of this policy under Medicaid yet are unfunded under TANF. To that extent, this policy is a cost shift to States.

Use of Tamper Resistant Prescription Pads (-$210 million/5 years)
The Administration's budget proposes to require all states to use tamper resistant prescription pads as a way to reduce drug diversion and fraud.

Expansion of SSI Electronic Asset Verification Demonstration (-$640 million/5 years)
The President's budget proposes to expand a demonstration currently running in New York and New Jersey to electronically verify assets for SSI eligibility, to Medicaid.

Reduced Federal Assistance for Failing to Meet Federal Goals (-$330 million/5 years)
The Administration proposes reducing Medicaid assistance to states if they fail to meet certain goals such as reducing the use of restraints in nursing homes, recovering improper payments, coordinating care, and reducing the use of nursing homes among those under 55 years of age. While this proposal sounds reasonable on its face, it will be very difficult to actually measure these changes at the state level. Existing data are poor and individual states' success or failure will rest on the ability to come to agreement with CMS on the baseline from which they are measured. This will provide CMS with an opportunity to reward political allies and extort program changes from political foes.

Reductions in Payments to Providers for Third Party Liability, including for Prenatal and Preventive Pediatric Care (-$85 million/5 years).
The President's budget request proposes allowing States to withhold payment from providers for prenatal and preventive pediatric care where a non-custodial parent may have insurance and potentially be liable for payment. While the budget states that it will protect providers, women, and children, it provides no details as to how this policy would be implemented without restricting access to care or reducing or delaying payments to pediatric providers. The policy would also allow States to use liens against liability settlements to recover Federal matching payments, but no additional details are provided. Additionally, the states would also collect for medical child support where health insurance is derived from a non-custodial parent's obligation to provide coverage and recover Medicaid expenditures from beneficiary liability settlements.

Extend 1915(b) Waiver Period. (No cost)
The President's budget proposes to extend the 1915(b) waiver period from two years to three years.

Medicaid Regulatory Proposals (-$12.7 billion/5 years)[9].

The President's budget includes a number of regulatory changes that will reduce Medicaid spending by $12.7 billion over the next five years or $30 billion over 10 years. Many of these changes will affect essential community providers and may negatively

[9] Analytical Perspectives, President's Fiscal Year 2007 Budget, table 25-2 p. 363.

affect access to care both for those covered under Medicaid and others who rely on these providers for their care.

Reductions in Payments to Governmental Providers (-$5.0 billion/5 years).
The President's budget proposes $5.0billion in cuts to payments to providers over five years by prohibiting States from paying Government providers such as nursing homes and hospitals more than their "cost" to treat individuals and limiting the use of certain Certified Public Expenditures. This proposal was published as a proposed rule on January 18, 2007.[10] This highly restrictive new payment limit for public providers would drastically limit Medicaid support for the mission of safety net providers.

Under current law, Medicaid can pay Government-owned providers up to the Medicare payment rate which can be higher than Medicaid rates (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 can be required to return the 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 healthcare 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.

The Administration previously sent a legislative proposal to Congress on this matter, but it was not enacted because many questions remain including how the Administration would define a provider's "costs" for this purpose and what kind of reporting burden this will place on providers and States to document costs. It now appears that the Administration believes it can do this through regulations. Other issues are whether the Centers for Medicare and Medicaid Services (CMS) will apply a uniform policy to private and public providers, State and local providers, and across different States. In contrast, Congress has been moving away from paying providers based on costs in Medicare.

Elimination of Graduate Medical Education Payments In Medicaid (-$1.8 billion/5 years)
The Administration proposes to eliminate payments for Graduate Medical Education in the Medicaid program. This funding is used by facilities to train medical residents in hospitals and other settings.

Reductions in School-Based Administration and Transportation (-$3.6 billion/5 years).
The President's budget proposes administrative changes that would cut Federal payments for school-based administration and transportation services currently covered under Medicaid by $3.6 billion over five years. Few details are available on this policy. To the extent that States do not have the funding for these services under IDEA (Individuals with Disabilities Education Act), this proposal would be a direct cost-shift to schools, local governments, and States who are required by law to fund these activities.

[10] CMS-2258-P: ["Proposed Rules," Federal Register, Vol.72, No.11, Page 2236. 18 Jan 2007]

Stricter Reimbursement Policies for Rehabilitation Services ($2.3 billion/5 years).
The Administration plans to clarify through regulation the allowable services that can be claimed as rehabilitation services. Currently, rehabilitation services include any medical or remedial services recommended by a physician for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. Narrowing this further could result in beneficiaries losing needed and helpful services.

Clarification of Allowable Provider Taxes (No cost).
The President's budget proposes to clarify the current allowable provider tax policy under Medicaid. Last year's budget proposed cutting allowable provider taxes from six percent to three percent, and achieved a savings of $2.1 billion over five years. Currently, States are legally allowed to levy taxes of up to 5.5 percent[11] on different classes of providers (hospitals, HMOs, nursing homes, etc) so long as those taxes are generally broad-based and uniform. States use revenues raised through such taxes to increase provider payment rates under Medicaid. Additional details on the proposal are not yet available but if it is similar to last year's proposal, it will curtail the ability of States to increase provider payment rates. The result could be decreased access to services for beneficiaries.

Reductions and Delays in Payments to Pharmacies (No cost).
The President's FY2008 budget proposes to require States to exhaust all other third-party sources of payments before paying Medicaid pharmacy claims. Today, States are able to pay claims as received and then later bill other sources of coverage. This policy will result in payment delays for pharmacies, and may result in a reduced willingness of pharmacies to participate in the Medicaid program, reducing access to beneficiaries.

Issue Guidance Defining 1915(b)(3) Services (No Cost)
The FY 08 budget proposes to clarify by regulation which services may be allowed under 1915(b)(3) of the Social Security Act.

Codify Disproportionate Share Hospital Provisions in Regulation (No cost)
The President's budget also mentions issuing new regulations on disproportionate share hospital payments (DSH) and provider taxes. The Administration plans to clarify through regulation the statutory DSH program provisions, to ensure proper use of Federal funds. The Administration will also take steps, including revising regulations, to clarify and codify existing policies used to determine whether provider taxes comply with the statute. There is no score associated with these proposals and no further detail provided as to how they will affect different States.

[11] Congress reduced the allowable provider tax legislatively in 2006 to 5.5 percent over the next five years after which it will return to 6 percent.

New Medicaid and SCHIP Spending Proposals of $5.6 Billion Over Five Years

Extension of Transitional Medical Assistance ($665 million/5 years).
The TMA program, which provides health insurance for working mothers as they transition from welfare to work, will expire in June of 2007. The President's budget assumes Congress extends the program through the remainder of 2007, and then would extend TMA for an additional year through September of 2008 at a cost of $460 million in 2007 and $665 million over five years. Unlike most healthcare programs for low-income individuals, this program relies on year-to-year funding, making long-term planning by States difficult and threatening the stability of the program.

Extension of Qualified Individual Program ($425 million/5 years)
The Qualified Individual (QI) program pays Medicare Part B premiums for Medicare beneficiaries with incomes between 120 and 135 percent of poverty.[12] Funding for this program is set to expire in September of this year. The President's budget assumes Congress extends the program through the remainder of 2007, and then would extend the QI program for an additional year through September of 2008 at a cost of $425 million over five years.

New SCHIP Funding ($4.8 billion/5 years)
The budget includes a total of $4.8 billion of new money over five years for the SCHIP program. Starting in 2009, the President proposes to add $227 million to the SCHIP program, and then about $1.5 billion in the subsequent three years.[13] This would increase SCHIP spending by $5.9 billion over 5 years as compared to the baseline. However total SCHIP spending is only increased by $4.1 billion over five years due to a Medicaid offset of $1.77 billion. The new money added to the SCHIP Program is inadequate to meet the need, even when including the old money redistributed through the Presidents 3 to 1 proposal and the proposal to reduce federal assistance for certain children, parents and pregnant women.

Reductions in Federal Assistance for Coverage Through SCHIP (effect unclear)
The President's FY 2008 budget proposes reducing federal funding available for states to cover children through the SCHIP program. States that cover children over 200% of poverty would no longer receive enhanced federal assistance for that coverage. This amounts to changing the rules of the game mid-stream, as the SCHIP statute specifically allowed states to reach children above 200% of poverty. In addition, the FY 08 budget proposes reducing matching funds available for other populations covered through the SCHIP program, and would prohibit states from enrolling any new adults in their program, even if they could currently be covered today. This amounts to eliminating coverage for these populations as states are unlikely to have the resources on their own to continue coverage of these populations.

---

[12] ["Medicare Savings Programs: Helping Your Clients Get and Use the Benefits," Center for Medicare Education. Issue Brief Vol. 5, No. 3, 2004] <http://www.futureofaging.org/PublicationFiles/V5N3.pdf>
[13] Office of Management and Budget back up tables for FY 08 Budget, p 845-846.

Redistribution of SCHIP Funding (effect unclear).
The Administration's FY2008 budget includes a proposal to allow States only one year to spend SCHIP funding rather than three years as is currently allowed. In 2007, approximately 17 States are projected to have insufficient Federal funding to provide coverage for eligible children under their SCHIP programs[14].

Health Insurance Portability and Accountability Act Proposals Related to Medicaid and SCHIP (no cost). Special Enrollment Period in Group Market for Medicaid/SCHIP.
As in the past three years, the Administration's FY2007 budget would make eligibility for SCHIP and Medicaid a "qualifying event" for the purposes of enrolling in employer-sponsored insurance. This proposal would allow beneficiaries to enroll immediately in employer-sponsored insurance rather than waiting until the employer's open season. The concern with this proposal is that for many beneficiaries who are eligible for Medicaid or SCHIP, employer- sponsored coverage may be inadequate, either in terms of paucity of benefits or unaffordable out-of-pocket costs. The Administration's budget does not include a requirement that in the event a Medicaid or SCHIP-eligible person were to enroll in employer-sponsored coverage, the State would fill in the gaps for missing benefits or excess costs to ensure that coverage under the employer plans meets the statutory requirements under Medicaid/SCHIP.

While the Administration has encouraged States to enroll Medicaid and SCHIP beneficiaries eligible for employer coverage in the employer-sponsored plan as a way to reduce costs in the Medicaid and SCHIP programs, the Administration's approach does not guarantee that families will get either adequate coverage or that it will in any way reduce costs for the State. Medicaid and SCHIP were specifically designed to address the needs of the poor, those with disabilities, and chronically-ill individuals whose needs were not being met in the marketplace. Making sure that an individual has access to the services they need will improve their health and lower long-term costs to the Medicaid program. For example, Rhode Island and New Jersey have documented program savings and provided coverage through Medicaid for costs and services that the employer-sponsored plans do not cover. In the other States that have pursued this approach, however, coverage is not required to meet Medicaid benefit and cost-sharing standards, and it is not clear that these States are saving money[15].

Creditable Coverage Certificates under SCHIP.
The Administration's FY2007 budget also proposes requiring States to issue certificates of creditable coverage to meet requirements of the Health Insurance Portability and Accountability Act that would allow them to move from SCHIP into private coverage without having preexisting condition exclusions (still verifying this last part).

---

[14] Center on Budget and Policy Priorities, Congress Can Preserve $1.1 Billion in Expiring Children's Health Insurance Funds and Help Avert SCHIP Cutbacks, September 28, 2004.
[15] Joan Alker, "Premium Assistance Programs: How are they financed and do states save money?", Kaiser Family Foundation, October 2005.

Refugee Exemption Extension ($99 million/5 years)
This extends for an additional year the current seven-year exemption for refugees and asylees to complete the citizenship application process without penalty. It is a Social Security Administration proposal which has the effect of increasing Medicaid spending by $99 million over five years.

Affordable Choices Coverage Program (budget neutral)
The Administration proposes a new budget neutral program, to free up funding for states to cover new people. This program would take funding away from institutions that provide uncompensated care serving low-income, uninsured, and under-insured Americans and allow states to use that money to purchase private insurance coverage for uninsured people. As this proposal is budget neutral, and provides no new money for coverage, it is merely robbing Peter to pay Paul. The proposal appears to involve encouraging states to undo state benefit protections for the population that would be covered as well. There are no federal standards outlined for what sort of coverage or policies would be acceptable for the program. This approach appears to ignore public coverage as a means of promoting efficient, comprehensive coverage expansions, even though most states that have pursued major reforms have included this. It also would rely heavily on Secretarial discretion and waivers of current law to change the health system with little federal oversight, standards, or legislative authority. Given other proposals in the President's budget to weaken or eliminate state insurance standards, this Affordable Choices project would appear to provide a prime opportunity for the Secretary to coerce states into scaling back state protections in order to be granted a waiver for coverage expansions.

Medicaid and SCHIP Waivers.
The President's FY2008 budget references increased coverage gains under the Health Insurance Flexibility and Accountability "HIFA" waivers stating that "could expand coverage to nearly one million people."[16] It is important to note that while a number of individuals *may* receive coverage, those coverage gains are not guaranteed and the benefits they receive under these waivers are often inadequate and result in individuals being "under-insured." According to the Kaiser Family Foundation, using waivers for expansions has limitations because there is no new Federal funding associated with waivers[17]. Moreover, many States have used waivers as a way of addressing State budget shortfalls by reducing services under Medicaid. Under the HIFA waivers, States are permitted to reduce benefits, limit eligibility, and increase costs on certain groups of beneficiaries in order to "offset" the cost of providing reduced-benefits package to people who today are not covered under Medicaid[18]. States, however, are not required to implement all or even part of the promised coverage expansion.

---

[16] President's Fiscal Year 2008 Budget in Brief, Department of Health and Human Services, p 65.
[17] The Kaiser Commission on Medicaid and the Uninsured, Federal Medicaid Waiver Financing: Issues for California, July 28, 2004.
[18] Ibid.

The President's budget also discusses implementing new "market-driven" approaches in Medicaid, such as the one being implemented in Florida that provides enhanced benefits to those living healthier lifestyles. This builds on the Health Opportunity Accounts in the Deficit Reduction Act (DRA). The DRA permits States to provide a select group of Medicaid beneficiaries a lesser benefits package with higher cost-sharing, something more akin to market-driven private health insurance plans such as high-deductible plans. It has already been shown that cost-sharing inhibits access to needed care, particularly among low-income individuals[19]. Furthermore, according to the Congressional Budget Office, about 1.6 million enrollees will be affected by the year 2015 and will lose services such as dental, vision, mental health, and certain therapies.[20]

MEDICARE

The Medicare program provides health insurance coverage to nearly 44 million seniors and individuals with disabilities. The President's FY2008 budget includes substantial cuts to Medicare providers such as doctors and hospitals while protecting private plan overpayments to HMOs and PPOs. The budget ignores problems with the new Medicare Part D benefit that went into effect on January 1, 2006, and offers no remedies to make it work. The budget proposes legislative changes that would cut $66 billion from the Medicare program over five years, as well as a number of regulatory changes[21] that would make additional cuts of $10 billion over five years to payment rates for a five year total of $76 billion in cuts to Medicare. Over ten years the President's proposed legislative proposals would yield $252 billion out of Medicare and the regulatory proposals would yield an additional $27.3 billion. Hospitals bear the brunt of the cuts to providers in the FY2008 budget.

Forty-five Percent Trigger for Cutting Medicare Across the Board.

The President's FY2008 budget includes a program cap that would automatically cut Medicare payment rates by four-tenths of one percent in the first year in which general revenues are projected to exceed an arbitrarily set cap of 45 percent of program spending. The reduction would grow by four-tenths of one percent every year that the 45 percent threshold is exceeded. This would mean payment cuts to all providers in Medicare. The proposals in the President's budget would push the 45% trigger outside of the current budget window, so the automatic cut would not be triggered.

Under the Medicare Modernization Act (MMA) of 2003, there is already an expenditure cap of 45 percent in law. When the Medicare trustees project for the second time that the general revenue funds share for Medicare expenditures will exceed 45 percent in any of the next seven years, two things would occur: (1) the President would be required to submit legislation to Congress, and (2) a new Senate rule would automatically come into effect barring consideration of any improvements in Medicare or any Medicare payments

---

[19] M. Edith Rasell, *Cost Sharing In Health Insurance – a Reexamination,* the New England Journal of Medicine, April 27, 1995, reviewing Joseph P. Newhouse, *Free for All? Lessons from the Rand Health Insurance Experiment,* Cambridge, 1996.

[20] Congressional Budget Office Cost Estimate, S. 1932, Deficit Reduction Act, January 27, 2006.

[21] This includes regulator changes already finalized that the Administration has included in its budget.

to providers unless any extra costs are fully offset. Even given this law, the President decided to put forward a more restrictive proposal in his budget.

Medicare Part D - The Medicare Prescription Drug Program.
The President's budget fails to address, either legislatively or administratively, the numerous problems that have plagued the new privately-run Part D benefit. In fact, there is no mention of such problems anywhere in the budget document. The budget fails to include any proposals that would: (a) address the confusion associated with the privately-run benefit by increasing funding for beneficiary assistance or by simplifying choices; (b) address denials of prescription drugs through excessive prior authorization and confusing appeals processes run by the private plans; or (c) provide beneficiaries with the low prescription drug costs obtained by other Government programs.

Part B and D Premium Increase (-$7.1 billion/5 years in Part B; -$3.2 billion/5 years in Part D).
The President's FY2008 budget also proposes increasing the Part B premium for more beneficiaries. In 2003 the Medicare Modernization Act changed Medicare's universal social insurance structure by relating premiums to income for the first time. As part of the MMA, beginning this year, individuals with higher incomes are going to be forced to pay more for Medicare Part B than lower-income Medicare beneficiaries, phased in over five years through 2009[22]. Higher-income beneficiaries were already paying a greater amount into the Medicare system through a payroll tax during their working years. This was the first step in turning Medicare into a means-tested welfare program.

The President's FY2008 budget now proposes another increase in premiums by eliminating the indexing of the income levels for individuals that will be subject to the premium increases. So, despite the fact that inflation and other factors will drive a person's income up over time, the level used to determine when a person would be required to pay higher amounts for their Part B premium does not proportionately increase. The end result is that more and more beneficiaries would become subject to increased premiums every year, forever.

For example, under current law only 3.8 percent of Medicare beneficiaries B nearly 1.6 million people B will be subject to this limit on government assistance in paying their premiums in 2007 and 3.9 percent of beneficiaries, or a little more than 1.9 million people, will be subject in 2016. Under the President's budget proposal, by 2016, double that number B 7.5 percent of beneficiaries or 3.8 million people B would be subject to these higher premiums[23].

In addition, the FY 2008 budget would also apply this ill-advised policy to Part D premiums as well.

---

[22] The Deficit Reduction Act, signed into law in February of 2006, accelerated the increase in Medicare Part B premiums so that the premium increase takes full effect by 2009 as opposed to 2011.
[23] Democratic Staff, Committee on Ways and Means, Fact Sheet: Charging Higher Income Medicare Beneficiaries More, February 7, 2006; Medicare Part B Tables for FY2007 President's Budget, January 11, 2006.

Health Care Fraud and Abuse Control Program (HCFAC) ($118 million/5 years).
The President's budget proposes to fund the HCFAC program through both mandatory and discretionary funding streams. The FY 2008 HCFAC program level is $1.3 billion, over $200 million more than in FY 2007. Of this total program level, $1.1 billion is mandatory and $183.0 million is discretionary. The majority of the additional discretionary funding would be for safeguarding the new Medicare prescription drug benefit and the Medicare Advantage plans against waste, fraud, and abuse. The remainder of the funding would be to expand program integrity oversight of the Medicaid program.

It has been shown that the Government receives a return investment of nearly 9 to 1 for every dollar spent on healthcare fraud and abuse activities[24]. This does not even include a calculation of the deterrent effect these activities have on fraud and abuse[25].

The new Medicare prescription drug benefit is fraught with confusion as a result of the many private plan choices Medicare beneficiaries have, the plans different benefit structures, formularies, and marketing strategies and the fact that many vendors offer not only a standalone Medicare prescription drug plan but also a Medicare Advantage plan. All of this confusion makes the Medicare program particularly susceptible to fraud and abuse.

Medicare Contractor Reform.
The President's budget proposes accelerating by two years the implementation of contractor reform, completing the task in 2009 rather than 2011 as was statutorily directed under the Medicare Modernization Act. In addition, the Administration proposes consolidating contractors from the 40 that serve Medicare Parts A and B today to only 15 joint A/B contractors in single or multi-State regions.

Provider Payment Cuts in Traditional Medicare.
The Medicare Payment Advisory Commission (MedPAC) annually recommends a number of payment changes including cuts and freezes to a variety of Medicare providers. The President decided to integrate only a few of the recommendations having to do with cuts and freezes to providers such as hospitals and skilled nursing facilities into his budget. The President chose not to eliminate the approximately $50 billion of overpayments to HMOs and PPOs through the Medicare Advantage plans as MedPAC recommended. The President's budget goes at the heart of the Medicare program. Rather than achieving savings by reducing the nearly $50 billion in overpayments to HMOs and private insurance plans, the budget cuts come solely to providers serving beneficiaries in fee-for-service Medicare, which enrolls more than 85 percent of all seniors and people with disabilities. Below is additional detail on the provider cuts in the President's budget:

---

[24] Taxpayers Against Fraud, Fighting Medicare Fraud, June 2003.
[25] Taxpayers Against Fraud, Fighting Medicare Fraud, June 2003.

- ***Physicians.*** For 2008, MedPAC is expected to recommend giving physicians an update that reflects the change in input prices less a productivity adjustment. The President's budget includes no provisions on this matter, and does nothing to address the significant Medicare payment cuts that will be made to physician payments over the next 10 years beginning in 2008. The Tax Relief and Health Care Act of 2006 eliminated the previously scheduled 2007 physician update of -5 percent and replaced it with a zero percent update. In addition, a 1.5 percent bonus payment was established for physicians who report quality measures in 2007. However, this act failed to address the cuts in future years and the President's Budget fails to address the 10 percent cut in physician payment that is pending for 2008 or the 5 percent cuts that doctors are scheduled to receive in subsequent years. The budget merely notes the Administration wants to work toward a policy that is budget neutral (meaning the anticipated cumulative cuts of 40% would go into effect) and provides some protection for premiums.

- ***Hospitals.*** Hospitals bear the brunt of the Medicare payment cuts in the President's FY2008 budget.

- ***Cuts on Inpatient Hospital Update (-$13.8 billion/5 years).*** For FY2008 the President's budget would implement a permanent cut of market basket minus 0.65 percent.

- ***Cut to Outpatient Hospital Update (-$3.4 billion/5 years).*** Annual market basket reduction of 0.65% in 2008 and beyond.

- ***Cuts to Indirect Medical Education (IME) (-$4.4 billion/5 years).*** The President's budget proposes eliminating payments to hospitals for Indirect Medical Education (IME) for beneficiaries covered by a Medicare Advantage organization. Prior to 1997, hospitals received IME payments directly from Medicare, regardless of whether the patient was in Medicare fee- for-service or a private plan. The Balanced Budget Act of 1997 eliminated Medicare=s payment for IME for beneficiaries in private plans and instead added an IME payment on to the Medicare private plan payment rates. Unfortunately, the private plans did not pass this bump in payment to the facilities providing the care. Congress later changed the policy returning Medicare=s direct payments to hospitals for IME regardless of whether the patient was in fee-for-service or a private plan. (Private plans kept their IME payment too, so Medicare in effect is double paying for IME.) MedPAC has recommended eliminating the IME add on to private plans. Instead of following this recommendation, the President's budget proposes to again take the IME payment away from institutions, returning to the flawed policy of having IME flow through private insurance plans.

- ***Elimination of Payments to Providers for Bad Debt (-$7.2 billion/5 years).*** The Administration=s budget put forward a proposal to phase out Medicare payments for bad debt over five years. Currently many providers, such as hospitals and SNFs, are reimbursed for 70 percent of their bad debts. Bad debt payments are

intended to compensate providers when they are unable to collect beneficiary cost-sharing amounts, for example because a beneficiary does not have the means to pay the bill. It allows providers to continue to see Medicare patients but have a source of some relief from unpaid bills. The President's proposal will completely phase out these payments and leave providers with no options but to bear the unpaid bills all on their own, go after the sick and poor elderly and disabled individuals, shift bad debt costs to paying patients, or no longer see Medicare patients. This will be a great burden on many providers.

In addition, numerous other providers receive significant cuts:

- ***Skilled Nursing Facilities (SNFs) (-$9.2 billion/ 5 years).*** Freeze SNF payments for 2008, and reduce the market basket update by .65% in subsequent years

- ***Home Health (-$9.7 billion/5 years).*** Freeze home health payments through 2012, and a -0.65% adjustment to the update annually thereafter.

- ***Inpatient Rehabilitation Facilities (IRFs) (-$1.9 billion/5 years).*** Freeze payments for 2008, and reduce the market basket update by 0.65% in subsequent years.

- ***Hospice (-$1.1 billion/5 years).*** Annual market basket reduction of 0.65% in 2008 and beyond.

- ***Ambulatory Surgery Centers (-$90 million/5 years)*** Provide an annual market basket reduction of 0.65% in 2010 and later.

- ***Ambulance (-$360 million/5 years).*** Annual market basket reduction of 0.65% in 2008 and beyond.

- ***Clinical Laboratories (-$2.4 billion/5 years).*** Expand competitive bidding to include clinical lab services.

- ***Oxygen Rental (-$2.4 billion/5 years).*** The Deficit Reduction Act included a new rent-to-own payment policy for oxygen equipment. After a maximum of a 36-month rental period, all home stationary and portable oxygen technologies will be considered purchased by the Medicare beneficiary. Medicare will continue to pay for reasonable and necessary maintenance and service along with gaseous and liquid oxygen contents. The President's budget proposes to reduce that policy to 13 months, only for older oxygen technology. New technology would remain at the 36 month rental period.

- ***Power Wheelchairs Rentals (-$500 million/5 years).*** Establish 13 month rental period for power wheelchairs so that a beneficiary cannot purchase the wheelchair unless they rent it for the full 13 months.

- ***Establish Federal Data Sharing Clearinghouse (Medicare Secondary Payer) (-$640 million/5 years).*** Medicare secondary payer is the term used by Medicare when Medicare is not responsible for paying first, generally called coordination of benefits in the private sector. In 2001, Medicare hired a Coordination of Benefits Contractor to help maintain eligibility databases with regards to other health insurance that is primary to Medicare. This proposal would establish a federal data sharing clearinghouse to clarify and expand Medicare secondary payer requirements to employers who would be required to provide CMS with coverage information. This information would be used to ensure that proper payments were made by the responsible insurer and to recover improperly made payments.

- ***Extend Medicare Secondary Payer Status for ESRD from 30 to 60 months (-$1.1 billion/5 years).*** Under the Balanced Budget Act of 1997, Medicare is secondary payer for end stage renal disease (ESRD) services for the first 30 months if a beneficiary has coverage for ESRD through a group health plan; the group health plan would be the primary payer. The President's budget extends that to 60 months; however, there is no additional detail provided on this proposal.

- ***Adjustment for Hip and Knee Replacement in Post Acute Care Setting (-$2.4 billion/5 years).*** The President's budget offers no further detail as to how this savings is achieved. It could be through a direct payment cut, restriction on the billing procedures, or some other mechanism.

- ***Eliminate Payment for Never Events (-$200 million/5 years).*** Prohibit Medicare payment for preventable adverse events such as surgery on the wrong body part.

- ***Establish a Base Payment for 5 Post-Acute Conditions Treated in SNFs and IRFs. (-$2.9 billion/5 years).*** This proposal would move toward site-neutral post-hospital payments to eliminate incentives for choosing one site of service over the other due to payment differentials for five conditions commonly treated in these two types of facilities.

Productivity Adjustment. The President's budget also recommends a productivity adjustment to inflation updates for provider payments to account for new technology. This amounts to yet another provider cut as payments will be reduced upon the adoption of new technological advances that increase productivity. The budgetary impact is tied into the payment updates and/or freezes projected for different providers above.

Conclusion

In short, the President's Fiscal Year 2008 budget makes significant cuts in Medicare to fee-for-service providers totaling $252 billion over the next 10 years that will seriously impair the ability of Medicare to continue providing the same high-quality care seniors and people living with disabilities have come to depend on. At the same time, the budget fails to address the documented overpayments to private healthcare plans, creating an

unlevel playing field and unfair competition. These plans will use their extra payments to enhance profits and lure healthy beneficiaries out of the quality care in fee-for-service with the promise of Aextra benefits, creating more difficulties for those remaining in fee-for-service Medicare.

In addition, the lack of any measure in the President's budget to address the many documented problems with the Medicare prescription drug benefit is a real failure for the millions of seniors and people with disabilities, particularly those with low and modest incomes, who have no choice but to try to receive their medicines under this program.

Finally, the addition of a cap – a trigger - on the program, as described above, and an automatic cut to providers if general revenues exceeds program spending could result in major reductions to Medicare benefits.

HEALTH TAX AND UNINSURED PROPOSALS

More than 46 million Americans today have no health coverage. Under President Bush's watch, there are six million more uninsured Americans today than when he took office[26]. The Administration is proposing a range of tax incentive and policy changes to promote greater enrollment in high-deductible plans that are linked to Health Savings Accounts (HSAs). They also want to move families from comprehensive coverage to more restrictive coverage in the individual insurance market that is fraught with problems today. These proposals drain $139 billion over five years**, increasing to $43 billion over 10 years from the treasury,** and would do little to improve the problems Americans are facing, but may in fact do great harm. In addition, by increasing the deficit, the President's policies create a justification for further Medicare and Medicaid cuts that will only further increase the number of uninsured and underinsured Americans.

Moreover, juxtaposed against the significant cuts – roughly $300 billion[27] over the next 10 years. President Bush has sent a clear message to working families that he wants to cut benefits and increase costs. Today these families have coverage that meets their medical needs. President Bush wants to replace that coverage with less than adequate, bare-bones packages with greater out-of-pocket costs. In other words, giving working families less and making them pay more for it.

Health Savings Accounts (HSAs) Proposals (-$3.7 billion/5 years; -$10.4 billion/10 years)

A Health Savings Account (HSA) is a tax-exempt account that is used to pay or reimburse certain medical expenses for people who also have high-deductible health

[26] Center on Budget and Policy Priorities, Number of Uninsured Americans Continued to Rise in 2004, August 30, 2005.
[27] This includes Medicare and Medicaid legislative proposals as well as new finalized regulatory proposals included in the President's FY2008 budget.

plans (HDHP)[28]. Both individuals and employers may contribute to HSAs with pre-tax dollars. Account balances roll over from year-to-year and earnings on these accounts accrue tax free. Withdrawals from these accounts are not taxed if they are used to pay for qualified medical expenses, as determined by the Internal Revenue Service. The President's FY2008 budget includes a number of proposals related to HSAs:

Allow High-Coinsurance Plans.
In lieu of satisfying the minimum deductible requirement with HSAs, a plan could qualify as a high deductible health plan if it had at least 50% or higher coinsurance and a minimum (not maximum) out of pocket exposure as determined by the Secretary.

Allow Expenses from First Day of H.S.A. eligibility.
Allows a taxpayer to use H.S.A funds to pay medical expenses before the H.S.A. was established, so long as the taxpayer has a qualifying high deductible health plan.

Allow Larger Employer Contributions for the Chronically Ill.
H.S.A contributions for chronically ill employees (or employees with spouses or dependents who are chronically ill) would be exempt from comparability rules. Comparability rules require employers to treat all employees equally, meaning the high level, lower level, sicker, and healthier employees have the same rules apply to them. This policy would allow the employer to contribute more to H.S.A. accounts of wealthier or healthier individuals.

Allow Individual Deductibles in HDHPs.
The FY 08 budget proposes to allow HDHP family policies to have individual deductibles embedded in the policy, so long as the deductible is at least as high as the qualifying deductible (i.e., $1,100 in 2007). Meaning that each individual in the family would have to satisfy a separate deductible in use of health services before insurers would have to begin paying on services.

Allow Spousal Catch-Up Contributions
Allows one spouse to make catch up contributions to the H.S.A. of another spouse if both spouses are eligible to make catch up contributions. This policy would disproportionately benefit the wealthy and could double the amount of money that a person can contribute to their H.S.A. through their spouse by further sheltering income from taxes.

Allow FSA and HRA Contributions to H.S.A.s: Allows workers currently enrolled in a flexible spending account or health reimbursement arrangement to contribute those funds to an H.S.A. but lowers the maximum allowable H.S.A. contribution by the amount contributed to the other policy.

---

[28] The deductible for high-deductible health plans is defined in statute (a minimum of $1,100 and maximum of $5,500 for an individual and $2,200 and $11,000 for a family under current law), on average more than three times the deductible in typical employer sponsored health insurance. These policies have an annual out-of-pocket – or catastrophic – limit and the insurer has the authority to determine which medical expenses count toward the deductible and out-of-pocket limit.

The President's HSA proposals spend a considerable amount of taxpayer dollars for covering few new people and a limited benefit to those who already have coverage. In addition, it has the potential to undermine existing employer sponsored health insurance coverage because healthier and wealthier employees will have the incentive to move to the individual market leaving sicker more expensive people in the employer sponsored health plans. In addition, these proposals have only a modest ability to control costs.

Health Coverage Tax Credit Proposals (HCTC) ($73 million/5 years and $190 million/10 years).

The President's budget includes a number of proposals that make changes to the Health Coverage Tax Credit (HCTC), created under the Trade Adjustment Assistance Reform Act of 2002 (TAA). This was passed to provide health insurance to people losing jobs due to trade agreements. The HCTC provides a refundable credit equal to 65 percent of the cost of qualified health insurance paid by individuals, such as recipients of TAA or Alternative TAA benefits, and certain individuals between the ages of 55 and 64 receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

- ***The President proposes to allow State-based coverage under the HCTC to impose longer pre-existing condition waiting periods.*** The law currently only allows only a three month pre-existing condition restriction, and the President's budget proposes to allow plans to impose 12 months of pre-existing condition restrictions. The stated rationale is to conform the HCTC to existing rules under the Health Insurance Portability and Accountability Act, but the real effect of this policy will be to deny individuals coverage of critical benefits when they are in need.

- ***The President proposes to allow spouses of HCTC-eligible individuals to claim the HCTC when the HCTC-eligible individual becomes entitled to Medicare coverage.*** The spouse would have to be at least 55 years old. This will help a small number of married couples who are insured through HCTC where one spouse ages into Medicare but the other is not yet eligible.

- ***Other Changes.*** The President's budget also proposes a number of other changes to HCTC: (1) clarifies that individuals who receive one time lump sum payments from the Pension Benefit Guarantee Corporation (PBGC) and certain other PBGC payees are eligible for HCTC; (2) deems the Commonwealths and Territories to be "States" for the purposes of State-based coverage rules; (3) clarifies that State continuation coverage under State law would automatically qualify as "qualified health insurance" as Federally mandated COBRA continuation coverage does without meeting the requirements relating to State-based qualified coverage; and (4) applies the same list of "other specified coverage" to all eligible individuals by changing the definition of "other specified coverage" for "ATAA eligible recipients" to conform to the definition applied to other individuals.

Standard Deduction for Health Insurance

The President's Fiscal Year 2008 budget proposes a new standard deduction for health insurance ($7,500 for individuals and $15,000 for family coverage). Starting in 2009, taxpayers would not pay income or payroll taxes on the first $7,500/$15,000 of income, but insurance premiums paid by employees and employers would – unlike today – be treated as taxable income. This deduction would be allowed regardless of whether the insurance was purchased through an employer or through the individual insurance market. As with any deduction (as opposed to a credit), the value of the deduction increases with income because higher income individuals are in higher tax brackets. Therefore, the tax deduction saves them more per dollar than someone in a lower tax bracket.

Medicare, Medicaid, and SCHIP beneficiaries would not qualify for the standard deduction, nor would those claiming the HCTC or using tax-preferred distributions from HSAs or MSAs.

OMB estimates that 20% of people with employer-sponsored insurance would see an immediate increases in taxes under this plan. The value of the deduction is indexed to general inflation, which rises more slowly than heath insurance premiums, causing more people each year to see an increase in taxes as a result.

The proposal leaves in place current tax preferences for HSAs giving a strong bias in favor of taxpayers selecting these plans. In addition, the budget proposes eliminating other current law deductions for purchasing health insurance such as: the Medical Expense Deduction for Non-Medicare Taxpayers; the deduction for health insurance for the self-employed; and the tax preference for FSAs for health care expenses.

Association Health Plans and Health Insurance Market Place Proposals

The President's budget includes two relatively similar proposals intended to "transform" the health insurance market place and provide access to low-cost health insurance for more Americans – Association Health Plans (AHPs) and "Health Insurance Market Place" initiatives. Unfortunately, neither is likely to provide any benefit for consumers, and instead will make it more difficult for those with disabilities and chronic or other illnesses to get insurance coverage.

Association Health Plans.

AHPs would allow small businesses and the self-employed to pool together to purchase insurance without generally being governed by State consumer protection laws and oversight. Insurers could offer policies that exclude people with illnesses or disabilities such as diabetes or exclude important benefits such as maternity care or prescription drugs. Insurers could avoid State rules that require insurance companies to offer coverage to everyone or laws that prevent insurance companies from discriminating against the sick by charging them more or denying them coverage. Similarly, health plans could avoid State-based oversight and solvency requirements that are in place to

assure that individuals and businesses are not left with medical bills if their AHP plan goes out of business.

Allowing these AHPs to operate outside of the protections in State insurance markets will create an unlevel playing field, which will be detrimental to sicker individuals. The American Academy of Actuaries noted, "The consequence of different rules for AHPs versus State-regulated insured plans is a fragmentation of the market. This is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals."[29]

We already have experience with entities like AHPs, and that experience has been poor. Multiple Employer Welfare Arrangements (MEWAs) are very similar to AHPs. These entities have defrauded hundreds of thousands of Americans out of their health coverage, leaving them with hundreds of millions of dollars in unpaid medical bills. By 2003, the GAO reported that MEWAs had accounted for more than $250 million in unpaid claims.

Moreover, AHPs will do little to reduce costs or increase coverage and could actually increase the number of uninsured. According to a 2003 Mercer study, by creating AHPs, the sicker population is left behind in employer pools that purchase insurance products that adhere to state consumer protections. This will actually increase health insurance premiums for these employers. Moreover, the Mercer study concluded that four years after implementation of an AHP proposal, the number of uninsured would increase by one million[30]. And, it is important to note that already, those with employer coverage are paying the price of having so many Americans go with out insurance. Premiums for employer-provided family health insurance cost, on average, an extra $922 in 2005 to cover the unpaid expenses of health care for the uninsured. These added costs account for $1 out of every $12 spent for employer-provided health insurance.[31]

AHPs are likely to undermine and erode existing employer-based health insurance coverage. AHPs are likely to pull the healthy out of employer pools that purchase insurance products that adhere to state consumer protections by offering low premiums for skimpier benefits packages more likely to attract those who are well, leaving the sicker in employer-sponsored coverage. This will result in skyrocketing premiums for those left in employer coverage – raising costs for both the employer and the employees. In fact, the Congressional Budget Office reports that Association Health Plans would result in higher premium costs for 75 percent of employers[32]. And, according to the American Academy of Actuaries, AHPs are not expected to generate the higher provider discounts and lower administrative costs necessary to produce lower premium rates on a sustainable basis than premium rates currently available to small groups[33].

---

[29] American Academy of Actuaries, "Executive Summary: Association Health Plans," May 2004.
[30] Mercer Consulting, "Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers," June 2003.
[31] Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured,* June 2005.
[32] CBO Paper, Increasing Small Firm Health Insurance Coverage Through Association Health Plans and HealthMarts", January 2000.
[33] American Academy of Actuaries, "Issue Brief: FAQs on AHPs," March 2005.

Numerous consumer groups have expressed concern that AHP's will cause harm to the existing insurance market place. For example, Families USA wrote, "We are very concerned that this law would encourage a race to the bottom in healthcare coverage, removing critical State consumer protections, creating unstable insurance markets, and increasing the potential for more insolvent plans."[34]

Health Insurance Market Place Initiative.
The President's FY2007 budget includes a proposal that would allow insurance companies to sell insurance across State lines without meeting the consumer protection requirements or other laws in other States. This is a flawed and misguided proposal that undermines State consumer protections and patient protections and will likely provide less healthcare choices, particularly for those who suffer from certain diseases or have disabilities. This proposal is similar to the Health Care Choice Act (H.R. 2355) ordered reported out of the House Committee on Energy and Commerce in July of 2005 by a vote of 24-23. Key concerns with this proposal are as follows:

The Market Place Initiative would erode consumer protections by permitting insurance companies to be licensed in one State but sell insurance in any other State, without meeting the laws of that other State.
Under this approach, insurers could circumvent State-enacted consumer and patient protections designed to ensure coverage of certain benefits or conditions such as cancer, diabetes, asthma, or mental illness. Insurers would be exempt from critical consumer protections such as guaranteed coverage for individuals with preexisting conditions, and required coverage of critical health benefits like mammography screenings and preventive care. Insurers could also avoid HIPAA-guaranteed access protections for those losing group coverage and moving into the individual market.

According to the Congressional Budget Office (CBO), this approach would cause those in poorer health to lose coverage in the individual market. They write, "there would be an increase in the number of relatively healthy individuals, and a decrease in the number of individuals expected to have relatively high cost, who buy individual coverage."[35]

The Market Place Initiative would raise costs for employer coverage as well as cause loss of employer-sponsored insurance.
According to CBO, "...some people with relatively low health care costs who, under current law, will obtain health insurance coverage through an employer, would choose instead to purchase individual health insurance coverage from an out-of-State insurer. That would increase the per-person cost of the employers' group health insurance and would result in additional employers deciding to drop the group coverage."[36] CBO estimates that about one million people would lose employer-sponsored health insurance coverage under such an approach.

---

[34] Families USA letter to U.S. House of Representatives, July 21, 2005.
[35] Congressional Budget Office, "Cost Estimate H.R. 2355 Health Care Choice Act of 2005," September 12, 2005.
[36] Ibid.

The Market Place Initiative would permit insurers to circumvent State consumer protection and patient protection laws such as those protecting consumers from unfair rates and rate hikes, or laws protecting coverage for particular conditions or benefits. This would clearly promote a "race to the bottom" as insurers would be greatly rewarded for licensing their individual products in States with less regulation and fewer personnel to oversee what could be a large influx of new products.[37]

The Market Place Initiative would create regulatory confusion and make it difficult for consumers to seek recourse for problems.
Under this proposal, there would be no effective enforcement mechanism to protect consumers as an individual's State insurance commissioner (who today ensures the consumer's rights) would not have the jurisdiction or ability to enforce rules for a policy issued through another State. According to the National Association of Insurance Commissioners, "state regulators would be unable to assist their own constituents, leaving consumers to seek assistance from the insurer's home state. While that may be a theoretical possibility, in the real world of tight state budgets it will be virtually impossible to assist a nonresident consumer in a distant state."[38]

The Market Place Initiative would hurt rather than help small employers to afford coverage.
According to the Blue Cross Blue Shield Association which operates 40 independently-owned and operated Blue Cross Blue Shield companies insuring more than 90 million Americans, "Although the bill does not apply to the small group market or to small businesses, it would have a negative impact on the ability of small employers to purchase affordable insurance. By creating a regulatory "race to the bottom" in terms of the non-group market, the Act would drain healthier employees from the small group market because they would be quoted very low (albeit unstable) premiums in the non-group market. When these healthy individuals eventually get sick, they would face dramatic premium increases from their unregulated insurers that would drive them back to the small group market. Federal law (HIPAA) requires that small employers accept these employees back onto their coverage plans. This would increase the cost of coverage for small employers purchasing coverage, as only higher risk employees remained in the pool."[39]

---

[37] Ibid.
[38] National Association of Insurance Commissioners, "Summary of Testimony Presented by the National Association of Insurance Commissioners on the Health Care Choice Act of 2005", June 28, 2005.
[39] Blue Cross and Blue Shield Association, "Blue Perspective," *A regulatory vacuume that hurts consumers; doesn't address small employer concerns,* 2005.

PUBLIC HEALTH AND FOOD AND DRUG ADMINISTRATION

Agency for Healthcare Research and Quality (AHRQ)

The FY2008 Budget request for AHRQ is $330 million, a net increase of $11 million over the President's FY2007 Budget. Most of this net increase -- $9.9 million – is earmarked for the Personalized Health Care Initiative that is proposed to receive a $15 million total budget in FY 2008 under the President's plan.[40]

A primary concern with the AHRQ FY2008 Budget is that support for comparative effectiveness research has been eliminated. In previous fiscal years, the $15 million requested for this research fell far below what was viewed by some as adequate for realization of this program's potential. Additionally, the President's Budget for FY2008 would reduce funding for the Administration's health information technology (Health IT) program by 10 percent. Health IT is thought to hold the promise for increasing health quality by reducing medical errors, particularly in ambulatory care, and for decreasing healthcare costs.

Administration for Children and Families (ACF)

The FY2008 Budget request for the ACF is $45.3 billion, a net decrease of $1.9 billion below the FY2007 Continuing Resolution and a decrease of $374 million below the President's FY2007 Budget.

The Administration requests a total of $191 million for abstinence education activities, an increase of $28 million over the FY2007 Continuing Resolution. The Budget includes $50 million in mandatory funds for the State Abstinence Education program and an additional $13 million for abstinence activities as part of the Adolescent Family Life program (outside of the ACF, located within the Office of Public Health and Science).

The Administration asks for increases in abstinence-only education programs despite the fact that a November 2006 Government Accountability Office (GAO) report found that the ACF does not review its grantees' education materials for scientific accuracy and does not require grantees of either program to review their own materials for scientific accuracy. The GAO further concluded that "because of these limitations, ACF cannot be assured that the materials used in its State and Community-Based programs are accurate."[41]

Funding for abstinence-only programs, which prohibit teaching about the use of condoms and contraception to prevent unintended pregnancy, HIV/AIDS, and STDs, is dramatically increasing. According to NARAL Pro-Choice America, this huge investment of taxpayer funds in abstinence-only programs conflicts with scientific and

---

[40] Alliance for Academic Internal Medicine.

[41] United States Government Accountability Office, *Abstinence Education: Efforts to Assess the Accuracy and Effectiveness of Federally Funded Programs*, (October 2006).

medical research: abstinence-only programs have never been proven effective and may result in riskier behavior by teenagers.[42]

Centers for Disease Control and Prevention (CDC)

The FY2008 discretionary Budget request for the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) is $5.8 billion, a net decrease of $20 million below the FY2007 Continuing Resolution and $33 million above the President's FY 2007 Budget.

The President's FY 2008 Budget fails to adequately invest in disease prevention and health promotion activities.[43] 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.[44]

One concern with the FY2008 Budget for the CDC is the level of support for the Adolescent Health Promotion Initiative. As the Administration notes, "Since 1980, overweight rates have tripled among America's children and adolescents, leading to the risk that the current generation may become the first generation in United States history that has a shorter life span than their parents."[45] During the past 20 years, obesity among adolescent has risen significantly in the United States. Among children and teens aged 6–19 years, 16 percent (over 9 million young people) are considered overweight. Despite the acknowledgement of a public health crisis, the Administration's Budget asks for a meager $17 million for the Adolescent Health Promotion Initiative, a program that would enable schools to take advantage of HHS science-based resources to slow the epidemic of childhood obesity. This request falls far below the level that some view as adequate for realization of this program's potential and continues to ignore and under-fund one of this country's most pressing public health issues.

Another concern with the Budget is that it continues to underfund diabetes prevention programs. The American Diabetes Association contends that the Administration and the previous Congress have not increased the Federal resources directed at diabetes in four years, while the disease has grown by nearly 30 percent in that same time period.[46] In this Budget proposal, CDC's Division of Diabetes Translation (DDT) – state-based diabetes prevention and control programs – would be flat-funded at $62.8 million, despite the fact that it historically has been unable to keep up with the dramatic growth of the disease.[47]

---

[42] NARAL Pro-Choice America. www.naral.org

[43] American Public Health Association.
[44] American Public Health Association.
[45] U. S. Department of Health and Human Services. *Budget in Brief, Fiscal Year 2008.*
[46] American Diabetes Association.
[47] American Diabetes Association.

Higher rates of diabetes and obesity threaten to reverse four decades of steady progress in the fight against heart disease and stroke.[48] In spite of this concern, the President's FY 2008 Budget does little to support cardiovascular disease prevention programs administered by the Centers for Disease Control and Prevention (CDC). Despite evidence that most cardiovascular disease can be prevented, prevention programs are flat funded for the second year in a row.[49] In addition, the President proposed zero funding for a program that can significantly improve survival rates from sudden cardiac arrest in rural communities.[50]

The FY2008 Budget proposal once again calls for elimination of the Preventive Health and Health Services block grant. This block grant has provided 61 States, Tribes, and territories with flexible funding that the grantee could direct as it deems appropriate. The Administration contends the block grant duplicates and overlaps other CDC programs.

In the FY2008 Budget, bioterrorism and public health preparedness programs receive significant cuts. A net decrease of $40 million is requested for programs that conduct bioterrorism preparedness activities. Additionally, the Administration requests a cut of $125 million to the Bioterrorism State and Local Capacity Program. The Trust for America's Health notes that these programs are designed to support upgrading State and local capabilities and ensuring hospital readiness, and that decreased funding will severely undermine emergency disaster response capabilities.[51]

Finally, the Administration's Budget proposes a $143 million cut to the Vaccines for Children (VFC) program, which helps families by providing free vaccines for eligible children. The CDC through the National Immunization Program administers this program at the National level. This cut is due to due to reductions in one-time mandatory costs.[52]

The President's FY 2008 Budget includes an increase in funding for pandemic influenza activities. These additional funds will help support the ability of the country to rapidly detect and respond to a potential outbreak, improve risk communications, and accelerate vaccine development.

Food and Drug Administration (FDA)

The FY2008 Budget request for the FDA is $2.1 billion, a net program level increase of $263 million over the FY2007 Continuing Resolution and an increase of $106 million over the FY2007 President's Budget.

The Administration's proposed budget for FY2008 contains increases in almost every program area, however, there are concerns that these increases are not adequate to ensure that FDA has what it needs to carry out its public health responsibilities. According to

---

[48] U. S. Department of Health and Human Services. *Budget in Brief, Fiscal Year 2008.*
[49] American Heart Association.
[50] American Heart Association.
[51] htttp://healthyamericans.org/reports/budget07/
[52] US Department of Health and Human Services. *FY 2008 Budget in Brief.*

the Coalition for a Stronger FDA[53] and the FDA Alliance[54], the lack of adequate resources has led to a severe reduction in public confidence in FDA. More resources can improve the frequency of monitoring domestic and imported sources of food and thereby reduce the incidence of food borne illnesses, which cause many persons to become ill or die each year.

Generic drugs can promote accessibility to drugs as well as compliance with drug regimes because they make drugs affordable for millions of Americans. More resources could significantly speed up the review process for generic drugs.

New drugs can provide therapies for those who suffer from diseases or conditions for which there is no treatment currently available. New drugs can also confer improvements over existing therapies, or over alternatives such as surgery. While user fees provide significant resources for review of new drugs, there needs to be some proportion to the relative mix of appropriations and user fees. The level of user fees relative to appropriated funds is a concern best addressed by increasing appropriations significantly over current funding levels.

Health Resources and Services Administration (HRSA)

The FY2008 Budget request for HRSA is $5.8 billion, a net decrease of $252 million below the FY2007 Continuing Resolution. The FY2007 Revised Continuing Appropriations Resolution increases funding for the Ryan White CARE Act and community health centers.

The Budget calls for near zero funding for the health professions and rural health programs. The Presidents' budget proposes a 30 percent reduction in Federal support for nurse training programs, zeros out funding for advanced education-nursing programs, and provides a modest increase for loan repayment and scholarship programs for nurses despite the continued challenge of health care workforce shortage in rural America and despite the fact that these programs are crucial to addressing the staffing needs of health centers across America.[55, 56]

As documented by the American Association of Colleges of Nursing, nursing schools are struggling to find adequate numbers of teachers to accommodate the rising interest in nursing careers among new students. A limited supply of students enrolled in graduate programs, coupled with an expected wave of faculty retirements, will further constrain the faculty population. Last year alone, AACN found that 42,596 qualified applicants were turned away from baccalaureate and graduate nursing programs due primarily to a lack of nurse educators.[57]

---

[53] www.fdacoalition.org
[54] www.strengthenfda.org
[55] The National Rural Health Association (February 5, 2007). *President's budget ignores critical role of rural health care programs.* Press release. Retrieved February 21, 2007.
[56] National Association of Community Health Centers.
[57] American Association of Colleges of Nursing.

Cutting programs that support the preparation of physicians, pharmacists, and other health professionals will likely limit the nations supply of health care providers and add to the growing issue of health disparities and access to quality health care.[58] As noted by the National Association of Community Health Centers, the Budget nearly eliminates Title VII Health Professions Training Programs, and contains a $10 million cut to the National Health Service Corps (NHSC), which helps medical students with tuition payments in exchange for service in underserved areas.[59] Cuts to the NHSC would hinder the Corps' effort to attract new doctors who can serve in medically underserved areas and freeze the number of NHSC awards. Also, cuts to the NHSC would hinder the expansion initiative for community health centers since more than half of all NHSC doctors serve in health centers today.[60]

The Natural Rural Health Association notes that, despite continued support from Congress, this is the fourth straight year in a row that the Administration has attempted to eliminate funding for several successful rural health programs and to drastically cut others.[61]

The Budget also eliminates programs dealing with traumatic brain injury, emergency medical services for children, and universal newborn hearing screening. Although the Administration increased funding for the Ryan White CARE Act, many organizations, such as The AIDS Institute, contend there will still be significant gaps between the resources provided and those that are needed for testing, prevention, and treatment of HIV/AIDS.[62]

The Administration proposed to increase funding for community health centers by a total of $207 million. Since Congress has expressed its intent that community health centers receive these funds as part of the FY 2007 Revised Continuing Appropriation Resolution, this may in effect equate to level funding. In FY2008, health centers will serve an estimated 16.3 million patients, 91 percent of whom are at or below 200 percent of the Federal poverty level, 64 percent of whom are from racial/ethnic minority groups, and 40 percent of whom are uninsured. These health centers are an integral partner in the care delivery system of our Nation and the Administration budget request is not adequate to meet the demands placed on health centers.

Indian Health Service (IHS)

The FY2008 Budget request for the IHS is $4.1 billion, a net increase of $212 million over the FY2007 Continuing Resolution and an increase of $101 million over the FY 2007 President's Budget.

---

[58] American Association of Colleges of Nursing. *AACN concerned that recommendations in the President's FY 2007 budget request would heighten the Nation's nursing shortage.* Press release. Retrieved February 21, 2007.

[59] http://www.nachc.com/press/02052007statementobudget.asp

[60] National Association of Community Health Centers.

[61] www.nrharural.org/about/sub/news/pres07budget.html

[62] www.TheAIDSInstitute.org

The Administration's Budget eliminates funding for the Urban Indian Health Program that ensures availability of or access to a comprehensive program of healthcare services for American Indians/Alaska Natives who reside in 41 urban cities. The National Council of Urban Indian Health suggests that the lack of urban health services would increase the gross health care disparities for American Indians and Alaska Natives.[63] More than half (57 percent) of the 2.5 million people who identified themselves solely as American Indian and Alaska Native in the 2000 Census live in metropolitan areas. Today, as many as 70 percent of Americans identifying as American Indians and Alaska Natives live in urban areas.[64]

National Institutes of Health (NIH)

The FY2008 Budget request for the NIH is $28.9 billion, a net increase of $232 million over the FY2007 Continuing Resolution. Note that the FY2007 Revised Continuing Appropriations Resolution increases funding for the NIH to levels that exceed the FY 2008 Budget request.

Although the President has publicly touted his support for the work of NIH as "one of America's greatest assets," his spending blueprint provides woefully inadequate support for NIH. The Administration's FY2008 proposed increase in NIH funding will not cover the cost of biomedical research inflation and therefore constitutes a cut in the actual level of resources NIH will be able to put forward to perform its public health mission. The actual level of direct NIH activity is also significantly reduced by the fact that NIH provides a significant amount of resources to other PHS agencies in the form of "planning and evaluation taps."

The erosion of the research capacity created just a few years ago by the doubling of NIH, combined with flat funding in recent years and the force of biomedical research inflation has eroded NIH's ability to maintain the momentum of innovative research and discovery that has resulted in dramatic declines in death from heart disease and cancer. In fact, many bright young investigators are increasingly choosing more lucrative careers in the private sector.[65] Cutting the NIH budget by over one half billion dollars will erode the vitality of our nation's medical research enterprise and leave millions of Americans without hope of the groundbreaking treatments they deserve.[66]

The President's FY 2008 Budget proposes reducing the National Cancer Institute's (NCI) budget for the second consecutive year, which would reduce NCI's budget by $9 million to $4.78 billion, although cancer is soon expected to be the leading killer of Americans. [67]

---

[63] National Council of Urban Indian Health.
[64] National Council of Urban Indian Health (February 5, 2007). *Administration proposes elimination of Urban Indian Health Program again.* Press Release. Retrieved February 21, 2007.
[65] Association of American Universities.
[66] Association of American Medical Colleges (February 7, 2007. *Bush budget targets medical education, patient care, and research*. Press release. Retrieved February 21, 2007.
[67] Lance Armstrong Foundation.

The Budget also underfunds diabetes research. Under the Administration's budget proposal, funding for the National Institute of Diabetes & Digestive & Kidney Diseases (NIDDK) would increase an inadequate 1 percent from the previous fiscal year.[68]

Substance Abuse and Mental Health Services Administration (SAMHSA)

The FY2008 Budget request for SAMHSA is $3.2 billion, a net program level decrease of $159 million from the FY2007 Continuing Resolution and $92 million below the FY2007 President's Budget.

The Administration proposes deep cuts to substance abuse and mental health programs that will impact some of the most vulnerable Americans, including seniors, low-income children, and the disabled.[69] More than half of these cuts -- of $83 million -- come out of substance abuse treatment and prevention activities, even though the Administration acknowledges that 23 million Americans struggle with a serious substance abuse problem for which treatment is needed and that the Substance Abuse Prevention and Treatment block grant "forms the cornerstone of States' and Territories' substance-related activities [and] support nearly two million clients annually."[70] Additionally, substance abuse can lead to lost productivity, domestic violence, child abuse, criminal involvement, and premature and preventable deaths.

The Budget includes $807 million for mental health services, which reflects a net decrease of $77 million from FY2007. These cuts are requested despite the Administration's acknowledgement that, "severe mental illnesses make it difficult to hold a job, go to school, relate to others, and cope with ordinary life demands,"[71] and that, in any given year, approximately 6 percent of adults have a serious mental illness and a similar proportion of children have a serious emotional disturbance.

ENERGY

Climate Change.

President Bush acknowledged the "serious challenge of global climate change" in his State of the Union address on January 23rd, but the federal response reflected in the 2008 Budget is modest indeed. DOE manages voluntary emission reduction registration under the Energy Policy Act of 1992 [Section 1605(b)], where the registry has been expanded to include farmers. The Department announced a "Climate Change Technology Program Strategic Plan" in September, 2006, to foster new technologies to "avoid, reduce, or capture and store greenhouse gas emissions." Counted within DOE's climate change programs is the Nuclear Hydrogen Initiative and other programs to maintain and expand nuclear capacity in the U.S. Also included is the Clean Coal Power Initiative, which is proposed to receive $73 million, including $58 million transferred from the Clean Coal

---

[68] American Diabetes Association.
[69] Catholic Charities USA.
[70] US Department of Health and Human Services. *FY 2007 Budget in Brief.*
[71] Encarta. *Mental Illness.* http://encarta.msn.com/encyclopedia_761566888/Mental_Illness.html. Retrieved on February 22, 2007.

Technology Program. The associated FutureGen project, a proposed emission-free coal-fired powerplant now in the process of identifying a site, is proposed to be funded to a level of $108 million, twice the prior year's level. New low-carbon and carbon-capture technologies may be a key element of the long-term solution to climate change, but the proposed 2008 budget simply lacks programs with near or mid-term effect in reducing carbon and other GHG emissions.

Advanced Energy Initiative.
Announced in the 2006 State of the Union address, the Advanced Energy Initiative gathered numerous programs related to enhancing domestic energy production and reducing dependence on imported sources. AEI is proposed to receive a 26% boost in federal funding for its second year, to a $2.7 billion total from $2.1 billion, but that hides significant cuts in funding for key elements relative to the 2007 budget requests submitted when the program was announced. For example, the FY08 budget request for solar programs amounts to $148.3 million, a $68 million decrease from the FY07 request. The wind program, at $40.1 million, represents a 9% cut from the FY07 request. The increase is targeted at biomass and biorefinery technologies, increasing by $29 million to $179 million relative to the FY07request, and at the Global Nuclear Energy Partnership (GNEP), that is slated to receive $405 million, up $155 million relative to the FY07 request.

The increase in spending for new nuclear power generation is more than matched by the amount proposed to be spent to move forward with disposing of the civilian nuclear waste from historic nuclear power generation, $495 million, primarily for the Yucca Mountain, Nevada, storage facility. This is a decrease from previous years, despite DOE's stated intent of filing for a license for the repository in 2008 and opening it in 2017. This decrease is of particular concern in light of the sharp increase in funding for GNEP, developing an unproven, long-horizon technology.

The Advanced Energy Initiative also includes a new program, the Twenty in Ten Gasoline Initiative, aimed at reducing U.S. gasoline consumption over the coming ten years (to 2017) through a combination of greater vehicle fuel efficiency and greater reliance on domestic alternative fuels, including renewable fuels, which would increase from the current minimum required sales of 7.5 billion gallons in 2012 to 35 billion gallons in 2017.

Energy Conservation and Efficiency.
Using less energy to obtain the same or greater production of goods and services – increased energy efficiency – is perhaps the most potent near-term opportunity to improve the national energy supply and demand balance, and in turn depends on both market and policy drivers. However, the proposed 2008 budget suggests diminished resources available for policy support, even where programs were already critically lacking adequate resources. For example, the weatherization program assists low-income households to reduce energy consumption while maintaining adequate comfort during cold weather. The 2008 request, at $144 million, is $20 million less than the 2007 request, and would leave the program less funded than in 2006 by $98 million. The

Federal Energy Management Program, which attempts to improve the energy efficiency of the federal government's own vast facilities, comprising the largest energy user in the economy, must absorb a $3 million cut from what was an insufficient $20 million budget in 2006. And state-operated energy efficiency programs funded by DOE grants to state energy offices have been proposed for steep cuts in funding from $49 million to $35 million for the base grants, despite an Oak Ridge National Laboratory study that indicated these programs saved $7 worth of energy for every $1 they spent – at a time when energy costs were much lower.

Low-Income Home Energy Assistance Program (LIHEAP).
Soaring heating and cooling energy costs are particularly hard to afford for low-income Americans, yet the LIHEAP funding intended to provide critical assistance is threatened with a reduction to little above half its 2006 levels despite dramatic fuel price increases during the period. Coupled with a special appropriation in the Deficit Reduction Act of 2005, LIHEAP funding reached a record level of $3.16 billion in 2006. Proposed appropriations in 2008 would add $1.5 billion in regular block grant appropriations to $282 million of emergency appropriations, for a total of $1.78 billion.

EPAct Authorizations.
Congress passed the Energy Policy Act of 2005 in the 109th Congress, and President Bush enthusiastically signed the bill into law in August, 2005. EPAct authorized many programs that articulated significant elements of the revamped national energy policy the bill was intended to establish. However, the President has proposed in his 2008 Budget to leave 93 of the line-item programs EPAct authorized wholly unfunded, including 17 in the biofuels and biomass area he has claimed to prioritize. His proposals would to limit funding of many others to small fractions of their authorized levels. EPAct-authorized levels of appropriations for Department of Energy programs for 2008 (including a continued LIHEAP authorization) were $17.9 billion; only $8.9 billion in spending is proposed by President Bush. If we are really to speak of an active national energy policy and strong efforts to deal with energy insecurity, the environmental consequences of energy use, and development of new energy sources and technologies for a new century, all as embodied in the provisions of EPAct, it is time to "put our money where our mouths are" and provide actual funding for the efforts Congress and the President agreed upon in that landmark legislation.

Food And Drug Administration, Office Of Internal Affairs
The HHS Office of Inspector General (OIG) is responsible for conducting investigations of FDA employee misconduct. Notwithstanding this fact, in 1995 the FDA created an Office of Internal Affairs (OIA), within the Office of Criminal Investigations, to investigate allegations of FDA employee misconduct. At the time, FDA explained that it had created OIA in consultation with the HHS Inspector General and described OIA's role as providing a "centralized investigative liaison between FDA and the OIG."[72]

[72] Letter to The Honorable Joe Barton, Chairman, Subcommittee on Oversight and Investigations, Committee on Commerce, U.S. House of Representatives, from Diane E. Thompson, Associate Commissioner for Legislative Affairs, Food and Drug Administration (August 2, 1995).

In reality, the practical effect of this reorganization of functions has been to shift investigative authority from OIG to OIA. FDA now has the lead in investigating itself. The Congressional Research Service (CRS), in a memorandum in which it directly addressed the creation of OIA, noted that OIA lacks the protections that insulate the Inspector General from outside influence and promote overall effectiveness. CRS went on to state that the consequence of FDA's system of self-investigation is "to open the process of investigating employee misconduct to a range of potential risks, including minimal or erratic documentation and case files, incomplete or untimely reporting to the Inspector General and others, and questionable decisions regarding a particular case."[73]

The internal investigations now conducted by OIA should be carried out by the HHS Office of Inspector General to maintain the integrity, impartiality, and accuracy of the investigative process. OIA currently employs 11 FTEs, all of which should be shifted to the HHS OIG to carry out these functions.

ENVIRONMENT

State and Local Air Quality Management

The President's FY2008 budget request would cut grants for State and local air quality management by $35 million, or 15 per cent of the amount enacted in 2006.

State and local governments have primary responsibility for ensuring that areas meet the health-based standards set by the Federal government. State and local air programs provide cleaner air, reducing pollution that causes asthma attacks, premature death, and other respiratory and cardio-pulmonary problems. For the key air pollutants, the Federal government sets the health-based level that is acceptable in outdoor air. States then are charged with developing plans and regulations to bring all areas in the country into compliance with these health-based standards. State and local governments, operating under Environmental Protection Agency (EPA) guidance, also are responsible for issuing all new source review and other clean air permits for sources under their jurisdiction.

The grants that the President's budget request cuts by 15 per cent are a significant source of funding for core State and local air programs. They provide funding that is used to pay State and local employee salaries and other expenses necessary to develop and run State and local air programs, including air permit programs.

Recent EPA actions have increased the workload on State and local air quality agencies. As a result of EPA actions in 2004 and 2005, more than 30 states are required this year and next to develop plans and adopt regulations that will limit air pollution enough to bring these areas into attainment of the national health-based standards for ozone and fine particles. In addition, EPA tightened the fine particle standard this past September, which will require states to adopt additional local controls.

---

[73] Congressional Research Service memorandum to The Honorable Joe Barton, Chairman, Subcommittee on Oversight and Investigations, Committee on Commerce, U.S. House of Representatives (November 14, 1995).

EPA has made the States' jobs more difficult because it is failing to meet its obligation to provide timely guidance regarding these State ozone and fine particle plans. Although EPA intended to issue this guidance in 2004 and early 2005, EPA delayed issuing the second phase of the ozone guidance until Fall of 2006, and parts of its ozone implementation rule were recently reversed by the Court of Appeals for failing to meet Clean Air Act requirements. EPA has not yet finalized the fine particle guidance, even though it was proposed over a year ago.

To justify the reduction in State and local air grants, EPA relies in part on its issuance of the Clean Air Interstate Rule (CAIR). CAIR is designed to reduce regional air pollution levels by reducing power plant emissions through a regional cap-and-trade program that must be adopted by States but would be run by EPA. Although CAIR will reduce pollution significantly, it does not bring all parts of the country into attainment with the health-based standards. In fact, EPA's analysis has shown that a tighter CAIR would have brought more areas into attainment at cost-effective levels.

Arguably, EPA's failure to adopt CAIR levels that would have brought more areas into attainment at cost-effective levels has increased, rather than decreased, States' workloads. To make up for the emission reductions that could have been achieved under a tighter CAIR, States are faced with either controlling local sources to make up the reductions that could have come from a more stringent CAIR or adopting a more stringent sub-regional power plant program. States in the Northeast, the mid-Atlantic, and the Midwest are actively considering programs more stringent than CAIR.

EPA cites the great progress that has been made on meeting health-based standards for carbon monoxide (CO) and lead, and thus the resulting reduced workload on States, as a major justification for the 15 per cent cut in State funding from FY2006 to FY2007. Most of that progress was achieved quite a few years ago, and it is unlikely that States have spent significant time or money on CO or lead standards in the last few years. Thus, EPA has not identified a change in circumstances that would cause a decrease in workload from FY2006 to FY2008. More importantly, the budget justification fails to increase funding for the States' increased workload to meet the PM2.5 and ozone standards.

Environmental Protection Agency

The Environmental Protection Agency's (EPA) FY08 budget request of $7.2 billion represents a $110 million dollar decrease from the FY07 budget request of $7.31 billion and a more than $400 million decrease from FY07 enacted levels. Since FY2004, the President's budget requests for the EPA have decreased by an amount exceeding $400 million. A four year look-back shows the enacted levels have fallen from $8.365 billion in FY2004 to $7.625 billion in FY07 – a decrease of over $700 million.

Leaking Underground Storage Tanks

The Energy Policy Act of 2005 included a major increase in the authorization for the Leaking Underground Storage Tank (LUST) program to $605 million for FY2008, including $400 million from the LUST trust fund for clean up of petroleum spills and leaks of oxygenated fuel additives such as MTBE. The law also continued a 0.1 cent per gallon tax on motor fuels that all motorists in America pay, which will add $199 million to the LUST Trust Fund in FY2008, bringing the total fund surplus to an estimated $3 billion. Interest on the Trust Fund is estimated to add an additional $109 million in FY08.

The President's budget, however, requests just $72.5 million from the Trust Fund for cleanups, which is slightly less than last year's appropriation. In short, the gasoline taxes paid by consumers are not going for their specified purpose -- cleanup of spills and releases that are contaminating water supplies.

In the meantime, there is a backlog of 113,919 cleanups not yet completed, and completed cleanups have declined from 18,518 in FY2003 to a "performance target" of 13,000 in FY08. The General Accountability Office recently released a state survey showing that it would cost $12 billion in public funds to clean up approximately 54,000 known releases where there is no viable tank owner or operator. The longer this contamination is left unaddressed, the greater the potential for it to spread, further putting human health and the environment at risk and increasing the ultimate cost of the cleanups.

Drinking Water State Revolving Fund (SRF) Grants

The Drinking Water State Revolving Fund (SRF) is designed to support states in helping public water systems finance the costs of infrastructure improvements needed to achieve or maintain compliance with Safe Drinking Water Act (SDWA) requirements and to protect public health. To reduce occurrences of serious public health threats and to ensure safe drinking water nationwide, EPA is authorized to make capitalization grants to states, so that they can provide low-cost loans and other assistance to eligible public water systems. For fiscal year 2006-2009, appropriated funds are allocated to the states in accordance with each state's proportion of total drinking water infrastructure need as determined by the 2003 Needs Survey and Assessment. According to the 2003 Needs Survey and Assessment, released on June 14, 2005, the total state need, including the District of Columbia and Puerto Rico, is $263.8 billion.

The President's budget request for FY2008 of $842.2 million is up $4.7 million from the FY07 request of $837.5 million, but down $7.8 million from the FY02 budget request of $850 million. While these budget requests have been relatively stable over time in nominal dollars, when adjusted for inflation in 2006 dollars, the President's budget request for FY08 is the lowest in the history of the SRF program. The following charts, prepared by the Congressional Research Service, show the budget requests with adjustments for inflation to 2006 dollars.

[SEE Appendix A: Drinking Water State Revolving Fund (SRF) Grants: Enacted]

Superfund

The Superfund program addresses public health and environmental threats from uncontrolled releases of hazardous substances.

Overall, the FY08 budget request for Superfund is $1.245 billion or $15 million dollars less than the President's FY07 budget request of $1.259 billion and $35 million less than the President's FY06 budget request of $1.279 billion. The FY08 budget request is also $7 million less than the FY07 enacted level of $1.252 billion.

These reduced budget requests come at a time when progress in completing construction activities at the Superfund National Priorities List (NPL) sites has slowed dramatically. The Superfund program averaged 86 construction completions at NPL sites for the four years from 1997 to 2000. For each of the past four years (2002-2006), however, the Superfund program achieved construction completion at exactly 40 sites per year. The President's budget request for FY2007 stated that the Environmental Protection Agency (EPA) "expects to complete cleanups at 40 Superfund sites" and further stated that "EPA will redirect resources from earlier phase activities toward construction to maintain progress in all Superfund response activities." But just recently, the EPA announced that it would only achieve 24 construction completions in FY2007 – a reduction of 40 percent. (See attached chart.) Rather than expediting the rate at which Superfund sites are cleaned up, EPA has failed to meet the agency's own 2007 projections.

The Congressional Research Service has prepared the following charts that demonstrate the loss of purchasing power for the Superfund program when the FY08 budget request is compared to previous enacted levels after adjustments for inflation.

[SEE Appendix B: Hazardous Substance Superfund Account: Enacted Appropriations]

The President's FY2008 budget 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."

The goal of the Superfund remedial program, a primary component of the overall program, is to provide long-term human health protection at the nation's most contaminated hazardous waste sites – those placed on the National Priorities List. Yet, enacted levels for the remedial program fell from $600 million in FY04 to $589 million in FY06 -- a decrease of $11 million. With an acknowledged backlog of remedial projects ready to begin construction, the budget requests $584.8 million for the remedial program -- four million less than the FY06 enacted level of $588.9 million and $3.2 million more than the FY07 budget request of $581.5 million.

Brownfields

The President's FY2008 budget request of $89.26 million represents an increase of approximately $160,000 from the FY2007 budget request of $89.1 million for Brownfields cleanup and assessment grants. However, the FY08 request is $31.2 million, or 26 percent less than his budget request of $120.5 million for FY2006. When the Small Business Liability Relief and Brownfields Revitalization Act was signed by the President in 2002, he talked about "requesting that Congress double EPA's Brownfield's funding" and described the bill as "a good jobs creation bill." The law provides an authorization of $200 million per year. But the President's budget request for FY2008, which includes a $23.5 million request for administrative costs, reflects just 56 percent of the amount authorized by law for cleanup and assessment grants (Section 104k).

The US Conference of Mayors and the Real Estate Roundtable have informed Congress that "at current funding levels, EPA can only fund about one third of the applicants for Federal brownfields grants. EPA has turned away over 800 applicants in the past two years.

TELECOMMUNICATIONS

Public Broadcasting

The budget proposes a reduction in public broadcasting funding. The Corporation for Public Broadcasting (CPB) customarily receives appropriations two years in advance, which maximizes the ability to leverage public dollars for additional sources of support. In 2006, Congress provided CPB with advance appropriations for FY 2008 of $400 million. The budget proposes to rescind $50 million of that advance appropriation.

In addition, rather than provide additional funding for the digital television conversion ($40 million requested for FY2008) and for upgrades to the public radio interconnection system ($27 million requested for FY2008), the budget proposes that CPB provide funding for those purposes out of its reduced regular appropriation ($350 million, of which CPB could spend up to $30.6 million for digital television conversion and up to $26.75 million for radio system upgrade). Refusing to provide for separate additional funds for the digital television conversion is of particular concern given that Congress set a firm date in February 2009 for the end of analog television. Additional digital television conversion funding could help public television make a smooth switchover and

continue its investment in digital content. In addition, upgrades in the Public Radio Satellite System will help maintain the transmission system to more than 800 public radio stations throughout the U.S. and its territories.

The budget once again declines to request the customary advance appropriation. From FY2002-2009, the President's budget has declined to request the traditional two-year advance funding for CPB. The practice of advance appropriations imposes no financial burden on the Treasury but provides certainty from which local stations can develop programming and raise other funding. For FY 2010, CPB has requested $440 million, an increase after four years of level funding. Although 80 percent of public broadcasting's annual funding comes from sources other than the federal government, stable federal appropriations in advance is the foundation upon which local public stations rely.

In addition to CPB, the budget also proposes to decrease funding for the public broadcasting community through the Public Telecommunications Facilities Program at the Department of Commerce and the Ready-to-Teach program at the Department of Education. PTFP is the only source of emergency funds for public radio and television stations in the event of an emergency, such as the loss of a transmitter due to a natural disaster.

Spectrum Matters

The budget proposes four matters pertaining to use of the electromagnetic spectrum:
(1) *Permanent Auction Authority* – The budget proposes to extend indefinitely the authority of the Federal Communications Commission (FCC) to auction spectrum licenses, which is currently set to expire in September 2011.
(2) *Spectrum License User Fee* – The budget once again proposes to permit the FCC to impose license fees on unauctioned spectrum license holders.
(3) *Ancillary Terrestrial Component Spectrum License Auctions* – The budget proposes to require the auction of the assignment of the land-based component of hybrid terrestrial-satellite communications networks such as Mobile Satellite Services.
(4) *Domestic Satellite Service Spectrum License Auctions* – The budget proposes to require the auction of spectrum licenses for predominantly domestic satellite services such as Direct Broadcast Satellite and Satellite Digital Audio Radio Services.

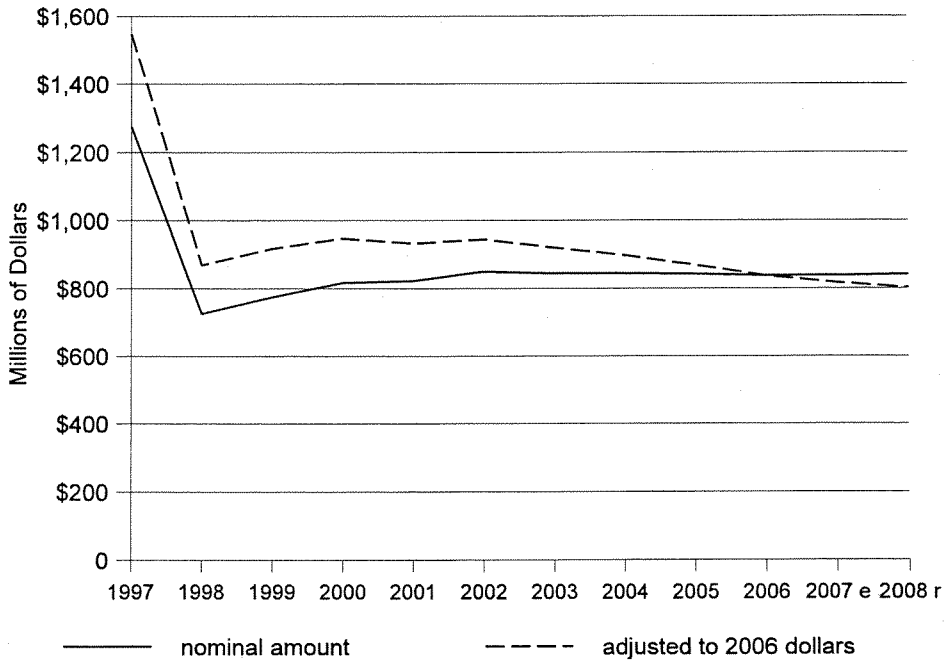
The Committee believes that all telecommunications policy matters, including rules regarding spectrum management, are best determined by the Committee through the normal legislative process. The telecommunications sector carries with it some of the most complex technical and public policy questions that are confronted by the Congress. Crafting sound policy in this area requires a level of expertise that the Committee is best able to provide. The Committee will work to ensure that the United States maintains a comprehensive and forward-looking spectrum management policy that inures to the maximum benefit of the American public.

Telecommunications Development Fund

The budget proposes to terminate the Telecommunications Development Fund (TDF). Having created TDF as part of the Telecommunications Act of 1996, the Committee continues to support the goals underlying the fund. The Committee will continue to monitor the fund to ensure that it continues to fulfill, in a prudent and responsible manner, its mission and goals as mandated by Congress.

Appendix A

Drinking Water State Revolving Fund (SRF) Grants: Enacted Appropriations FY1997 — FY2007 and FY2008 Requested

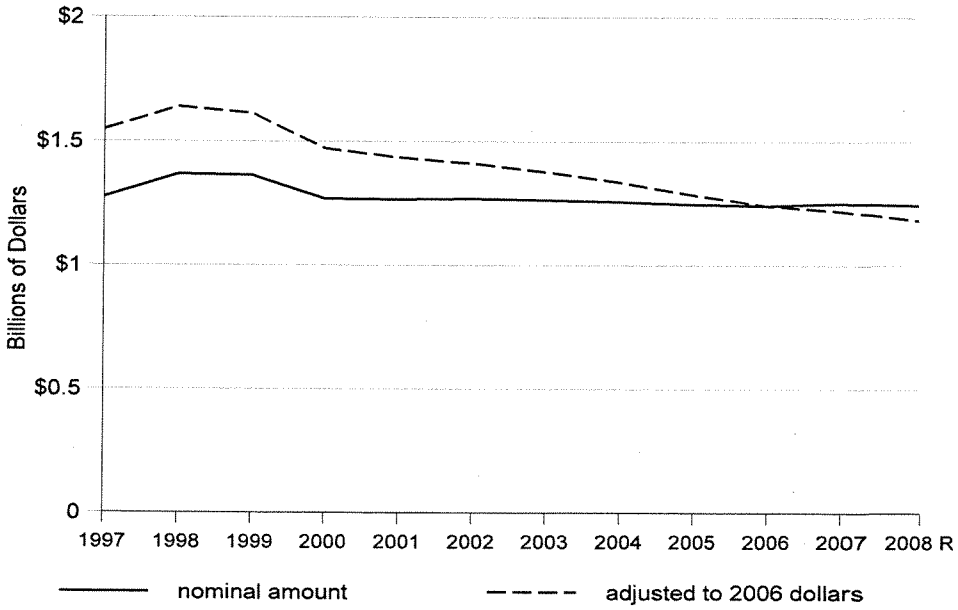


Drinking Water State Revolving Fund (SRF) Grants: Enacted Appropriations FY1997 – FY 2007 and FY2008 Requested

Fiscal Year	(in millions)	
	Enacted Appropriations Nominal Dollars	**Adjusted for Inflation in 2006 Dollars**
1997	$1,275.0	$1,547.0
1998	$725.0	$869.1
1999	$775.0	$917.0
2000	est. $816.9	$947.4
2001	$823.2	$932.7
2002	$850.0	$945.0
2003	$844.5	$920.3
2004	$845.0	$897.6
2005	$843.2	$869.2
2006	$837.5	$837.5
2007	est. $837.5	$816.8
2008	req. $842.2	$802.0

APPENDIX B

Hazardous Substance Superfund Account: Enacted Appropriations
FY1997 – FY2007 and FY2008 Requested



Fiscal Year	(in billions)	
	Enacted Appropriations Nominal Dollars	**Adjusted for Inflation in 2006 Dollars**
1997	$1.277	$1.549
1998	$1.368	$1.640
1999	$1.364	$1.614
2000	$1.265	$1.473
2001	$1.267	$1.436
2002	$1.270	$1.412
Supplemental	$0.041	$0.046
Total	$1.311	$1.458
2003	$1.265	$1.378
2004	$1.258	$1.336
2005	$1.248	$1.286
2006	$1.242	$1.242
2007	$1.252	$1.221
2008	req. $1.245	$1.185