S. HRG. 108–408

ADMINISTRATION'S HEALTH AND HUMAN SERVICES BUDGET PRIORITIES

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

FEBRUARY 4, 2004

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

92–774—PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
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WEDNESDAY, FEBRUARY 4, 2004

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:35 a.m., in room B–318, Rayburn House Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Nickles, Kyl, Thomas, Baucus, Breaux, Conrad, Graham, Bingaman, and Lincoln.

Also present: Hon. Tommy Thompson, Secretary, U.S. Department of Health and Human Services; Dennis Smith, Acting Administrator, Center for Medicare and Medicaid Services.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. I want to particularly, as a person from the other body, thank the hospitality of the House Ways and Means Committee and the House of Representatives during a time of very difficult scheduling for the U.S. Senate, wholly related to lack of space because of our office buildings being closed. I want to thank the Ways and Means Committee for responding to our request.

I want to obviously welcome all of you to this hearing that we have with our hardworking Secretary of Health and Human Services, Tommy Thompson, for the purpose of looking at the administration's health and welfare budget priorities for next year.

First and foremost, I think we need to thank the Secretary and his hardworking staff for their hard work and dedication last year as we worked our way through the Medicare Modernization Act.

Because of your leadership and expertise, we were able to follow through on a promise that we have made to our Nation's seniors over the last four or 5 years to modernize and strengthen Medicare by adding coverage for drugs.

However, we are not here to tout our accomplishments. Rather, we are here to discuss the future. One of these important challenges to us is the plight of 43 million Americans who do not have health insurance.

Last year, we were able to pass health savings accounts as part of Medicare modernization, and we created then the Health Coverage Tax Credit in the passage of the Trade Act of 2002. Unfortunately, we are not covering so many of the 43 million that we have, and this is a very high priority.

So I am anxious to hear from you, Secretary Thompson, what the President's proposals are to help with the uninsured. Consistent with the emphasis upon targeted help to those who need it most, the President has reaffirmed his continued commitment to helping the most vulnerable and needy citizens through the administration's welfare reform proposals.

One important feature of the President's proposal is the promotion of healthy marriages and strong family formation. These proposals are key provisions in the Welfare Reauthorization Act before the Senate. Enactment of a meaningful welfare reform reauthorization is a very high priority for me. It is one of the key pieces of unfinished business.

I am hopeful that the full Senate will consider that bill very shortly. I know that the Secretary has a keen interest in the welfare bill because of his work going way back when he was Governor of Wisconsin. I look forward to continuing that working relationship with him on welfare.

Another important priority that remains is improving the Medicaid program. I believe that one of the most promising Medicaid proposals in the Senate's budget is the one that gives the people with disabilities and older Americans more choices and more control over their benefits. Many of these Medicaid beneficiaries want options, including the ability to live in their own homes and direct their care.

The President has created opportunities for choice in his New Freedoms initiative, which includes "the money follows the person" proposal. These are important proposals and, in the coming months, I plan to focus on moving forward on these new approaches, creating better options for Medicaid beneficiaries who want to live in the community.

I am also very happy to see that one of the administration's continuing priorities for Medicaid and SCHIP is ensuring fiscal integrity, the President's budget proposals to build on past efforts to improve Federal oversight of these programs and ensure that Federal taxpayers' dollars for Medicaid are going to their intended purposes. With my strong commitment to program accountability, I want to assure everyone that this proposal is very much appreciated.

So, again, Mr. Secretary, thanks for coming to our committee, as you promised during confirmation that you would do. I look forward to working with you and the administration to accomplish the goals put in front of us by the President.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you very much, Mr. Chairman.

I, too, join you in thanking the House Ways and Means Committee for providing the space, Chairman Thomas, as well as Chairman Rangel, and all the staff. I know that a lot of the House staff came in very early this morning to help accommodate us. That is the usual House generosity, and we all deeply appreciate it.

I also thank you, Mr. Secretary, for going to the extra effort to try to find this place. It was a little difficult for some of us, I might say. I am glad you finally found it, too.

We are pleased to be here today, obviously. This is also a bit of a tradition, to talk to the Secretary when the new budget is submitted, and kind of take stock a little bit on where we have been and where we have yet to go.

Last year, of course, was very busy. None of us who were in Chairman Thomas' room are going to every forget the many, many hours and time we all spent together trying to hammer out good legislation.

I appreciate, Mr. Secretary, all the effort that you undertook that helped contribute to make that happen. It was a large bill and I was very proud to be a part of it. It represents the largest and most important expansion, as you know, of the program in about 38 years.

All beneficiaries will have access to a voluntary drug benefit beginning in 2006. That is a major accomplishment. That is whether they join a managed care plan or they stay in fee-for-service. Over one-third of beneficiaries will qualify for special low-income subsidies that would provide coverage for up to 84 percent of their drug spending.

The bill is not perfect, as we all know. But, as we all have said, too, perfection is usually not, and should not be, the enemy of the good. This is a good bill. It is certainly a very good first step and it does not undermine the traditional Medicare program, as some have claimed. I personally would never support legislation that I thought would undermine traditional Medicare.

Going forward, Congress has a responsibility to address any flaws or any issues that arise as implementation moves forward. And while I do not support undermining major elements of the bill that were signed into law last December, I do believe that there are several areas where we can make improvements.

For example, I am concerned about low-income beneficiaries who may pay more once the new benefit starts than they do under current law. I worry about the impact of formularies on our most vulnerable of beneficiaries.

The funding for States in the early years of the benefit may not be sufficient. It is not my intention that States would pay more for dual eligibles than they currently spend.

I also believe that the non-interference language has raised a lot of red flags regarding drug pricing practices. It was not our intent to create a government price control system, but it may be inappropriate to tie the government's hands so explicitly.

Perhaps even more significantly, the so-called true out-of-pocket provisions provide disincentives for employers, private plans, and Medigap to cover spending in the gap where they do not. They also need to be revisited.

Of course, these changes need to be weighed against budget constraints and other priorities. I look forward to working with my colleagues in a bipartisan way, working together as we have in the past, to make improvements to the bill as issues are identified that should, and could, be addressed this year and in the future.

Mr. Secretary, I would be remiss to move on to another subject without raising the issue of the administration's estimate of the Medicare bill. While Congress relies on CBO for its official estimates, we also very much rely on the independent career actuaries of CMS for their views and their analysis.

The actuaries' cost estimates were never supplied to the Congress, certainly not to me or my staff, that is, not until Monday, a couple of days ago, despite claims from you or your office to the contrary.

It would be disingenuous to claim that the higher score is my biggest concern. It is not. What concerns me most is the degree to which our access to CMS career actuaries has been restricted by this administration. In clear violation of the 1997 report language in the Balanced Budget Act, we have not had the access that that report language intended.

A thorough explanation of competing assumptions, for example, in the area of private plan participation, can inform the Congress as we move forward to make improvements to the bill.

Now, I agree with my colleagues that the Finance Committee should hold a hearing on this issue. Some have suggested that and I agree with that. I think we should hold hearings.

But, basically, we should try to figure out a way to solve this problem of the huge gap between CBO and HHS actuaries and the inability of us in the Congress or the public to know what the assumptions are behind those two competing sets of figures.

Also, it is my strong view that the administration has restricted Congressional and public access to career actuaries who have a lot more information than anyone else and who are there to supply information to all of us, not just the administration. A good example would be maybe the cooperation between Joint Tax and Treasury. They share information totally back and forth.

It seems to me that CBO and the actuaries at HHS should be in that same position because it will serve the public. This is not a matter of policy. This is not a matter of politics. It is a matter of getting the facts and getting the assumptions so we can get better policy and better solutions.

In fact, Mr. Secretary, I intend to introduce legislation to codify the 1997 report language, that Congress should have access to the CMS actuaries. It is the right thing to do.

Turning, now, to Medicaid. I was very disappointed to see that the administration is once again advancing an agenda that includes capped allotments for State Medicaid programs. Ironically, hard caps on Medicaid spending will reduce the flexibility of the program, not increase it. It is this flexibility that, over time, has allowed a swift response to economic recessions, high rates of uninsurance, epidemics, disasters like 9/11, and dramatic treatment innovations. We need that flexibility.

And, while I oppose block grants, or hard cap policy, whatever it is called, depending on the perspective of whether you like it or do not like it, I appreciate a legislative approach to Medicaid reform rather than simply imposing these caps in an aggressive use of Section 15 waiver authority.

The waiver authority was designed to allow demonstrations, pilot projects, experimentation, not wholesale changes of the entitlement

program. This is another area where I intend to introduce legislation this year. That is, to curb the administration's authority to abuse the waiver process.

I think Congress should set the standards of what the process should be, and I do believe, frankly, that the authority has been used much more than it has been intended.

A couple of points on TANF, which could see floor action very soon. My views on TANF reauthorization are well known. I was a strong, early supporter of welfare reform and I believe the program has worked, with roughly 50 percent reduction in the rolls.

But, while we need to get a bill done this year, I cannot lend support to legislation that would force my home State of Montana to scrap its successful welfare to work strategy and struggle to meet an array of new, unfunded mandates.

I have been very critical of the administration's marriage promotion initiatives and abstinence only initiatives. My criticism is twofold. First, I am concerned about government intrusion into our personal and private decisions. I worry about making sure families are safe from domestic violence. But I also believe that these dollars are better spent on work supports like child care.

In addition to our continued work on existing programs in the Finance Committee's jurisdiction, I am pleased that new issues are on the agenda, such as rising health care costs, the uninsured.

Health insurance premiums are increasing by double digits again this year, and the number of Americans without health insurance is on the rise. Uncompensated care will cost health providers more than $35 billion this year. The cost of our health care system affects the ability of U.S. companies to compete abroad.

For all these reasons, I am pleased that health coverage has again moved to the forefront. So what are we going to do about the uninsured? Several proposals are on the table that offer incremental solutions.

I propose tax credits to help small businesses provide, or continue to offer, health insurance for their workers. Senator Kennedy and Senator Snowe have proposed expanding the CHIP program to cover parents of eligible children.

The Chairman has proposed helping families of children with disabilities through the Family Opportunity Act. The Chairman and I have also proposed to expand the TAA health care tax for the unemployed.

I hope that the committee will consider these and others. These approaches make more sense to me than an individual tax credit for low-income populations. I am not convinced that the administration's tax credit proposal provides much help. I am also pleased that quality of care is part of the agenda this year.

My most recent brush with the health care system brought home to me the importance of access to excellent care. The doctors and nurses that took care of me at the Mayo Clinic in Arizona were some of the best I have ever encountered.

But not all Americans receive that kind of excellent care today. Reports from the Institute of Medicine have documented serious problems in patient safety and health care quality. One study recently showed that, on average, patients receive recommended care only about half the time.

I am pleased to see that the administration's budget contains support for Quality Improvement Organizations. In Montana, these QIOs have teamed up with local critical access hospitals to explore how to measure and enhance quality of care in small, rural areas.

In the coming year, I plan to develop ways to support quality improvement initiatives throughout the health care system, and I hope I can count on administration support. I know that I can.

Mr. Secretary, thank you. Thank you for coming. Thank you for your continued service. We are all in this together. As we were putting the Medicare bill together, we must continue to work together. I look forward to working with you. Doing so, I think we can get a lot done.

I also apologize to all of my colleagues, and thank them for indulging me in making my statement.

The CHAIRMAN. Before the Secretary speaks, I would ask our members to consider maybe if you would all keep within the 5 minutes that we have for exchange of views with the Secretary, questions, et cetera, because of the appearance of the leader of Spain before the joint session of Congress.

It is my intention to keep going until every member gets their questions asked. I suppose some of you want to go, and I would like to go, too, but I will put this meeting as the highest priority.

Mr. Secretary?

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

Secretary THOMPSON. Thank you very much, Mr. Chairman. Thank you, as always, for your hospitality, and that of Senator Baucus and all the members of this committee. It is always a privilege for me to appear in front of you, and it was a privilege for me to be involved in working with several of you in regards to the Medicare reform proposal.

I thank you for inviting me to discuss the President's fiscal year 2005 budget for the Department of Health and Human Services.

In my first 3 years at the Department, we have made tremendous progress in our efforts to improve the health, the safety, and the independence of the American people.

We continue to make extraordinary progress providing health care to seniors and to lower-income Americans, improving the well-being of children, strengthening families, and protecting the homeland.

We are building a new public health infrastructure to give doctors and hospitals the tools they need to respond to any public health emergency. We reenergized the fight against AIDS at home and abroad.

We increased access to quality health care, especially for minorities, the uninsured, and the under-insured. With your help, 2 months ago President Bush signed the most comprehensive improvements to Medicare since it was created nearly four decades ago.

To expand on our achievements, the President proposes $580 billion for HHS for fiscal year 2005, an increase of $32 billion, or 6 percent, over fiscal year 2004. Our discretionary budget authority

is $67 billion, an increase of $819 million, or a 1.2 percent increase, and an increase of 26 percent since 2001.

Five hundred and eighty billion dollars is a big number, and I have a solemn responsibility as Secretary to make sure that every one of those dollars is put to good, effective use. I owe it to the people who pay the taxes and I owe it to the people who consume the services.

We look forward to working with this committee and Governors to improve and modernize Medicaid and SCHIP by giving State governments greater flexibility to use consumer-directed services and to coordinate with free market providers.

We propose promoting home and community-based care as an alternative to institutionalization for disabled Americans through the President's New Freedom initiatives. I look forward to working with this committee on a bipartisan basis to get this important legislation introduced, passed, and signed into law this year.

President Bush seeks to build on the successes of the 1996 Welfare Reform Act by reauthorizing the successful TANF program to help more welfare recipients achieve independence through work, and protect children, and strengthen families.

I hope that under your leadership Congress will take the next step of welfare reform and complete the TANF reauthorization. We can, and we should, accomplish this critical goal this year.

The President and I have submitted a proposal, the House has passed a bill, and this committee has responded and reported legislation for the full Senate to consider, Mr. Chairman. Your bill represents many of the key principles that families need to move from poverty to self-sufficiency.

I urge you and your colleagues here in the Senate to pass the bill in the coming weeks. By doing so, you will help children escape poverty, give their parents the dignity of independence through work, because we all know that work is the road out of poverty.

Of course, the new Medicare Modernization Act is a significant accomplishment for our Department. Adding these benefits and choices and educating seniors about them will become a significant challenge.

You and your fellow lawmakers were right to follow the CBO score in making decisions. When CBO scores the budget, we submit today, it would be expected that their estimate would reflect $395 billion, or close to that number.

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

Thank you so very much for giving me this opportunity to make opening remarks.

The CHAIRMAN. Well, thank you very much. I will take 5 minutes, then defer to Senator Baucus. Then the order of arrival, or people that were here originally, by seniority, but the two kind of mesh together: Mr. Kyl, Mr. Breaux, Mr. Thomas, Mr. Bingaman, Mr. Hatch, Mr. Nickles, and Mr. Graham.

Mr. Secretary, as I mentioned in my opening statement, I believe the most promising Medicaid proposal in the President's budget is

the New Freedoms initiative. I am excited to work with you on this proposal that will create more choice for people with disabilities.

In that program, I know from my continuing work with the disability community that many of these Medicaid beneficiaries want options and the freedom that goes with those options, including the ability to live in their own homes and direct their care.

As I have said many times, no one is dying to get into a nursing home. At least, I have never heard anybody say that. The President has created opportunities for the choice in this New Freedoms initiative.

Could you please share with us some of the highlights of the proposal, including the concept of "money follows the person," and "living with independence, freedom, and equality," LIFE, accounts?

Secretary THOMPSON. Thank you so very much, Mr. Chairman. This is really a very compassionate and visionary proposal that the President has advanced. My Department has worked throughout the last 18 months putting together this proposal. We have held public hearings. We have had members from the community come in and advise us.

What we are trying to do, is we are trying to give individuals with disabilities the opportunity to manage their lives much better, to allow the money to be given to the individuals, not to purchase their medical care—that is going to be continued under the government's control and supervision—but to be able to purchase things.

Whereas, you may need to purchase an aide in order to be able to go to work, or you may need go be able to hire a baby-sitter to come in and take care of somebody in the family that is handicapped or has disabilities. The money is going to stay with that individual and the money is going to roll over.

It is going to be on a 5-year basis and the money will be able to continue. So if you do not use up all the money in the first year, you will be able to continue to advance that money, be able to use it in the second, third, and fourth year.

The individuals with disabilities have been very supportive of this particular proposition. We also want to allow individuals that are extremely capable to be able to manage their own money and be able to purchase the kind of services they need in order to improve the quality of lives, and that is what the Freedom initiative is all about. I applaud you, Mr. Chairman, for taking this cause on.

I encourage you to work with our Department, and I know I will work with you in order to advance it and get it to the floor, because I think this is going to be one of those stellar pieces of legislation that can receive great bipartisan support, and would be a tremendous help with individuals with disabilities.

I started this in Wisconsin when I was Governor, and it has worked out extremely well to keep more individuals in their own homes and being able to do things to manage their own money to provide a higher and better quality of life.

The CHAIRMAN. My last question before I go to Senator Baucus is, first of all, appreciating your bringing up the importance of getting welfare legislation passed, and hopefully before the March 30 extension runs out.

There should be little doubt in anybody's mind about the success of the 1996 legislation, how the number of people in poverty has been reduced and more adults are receiving assistance for work.

The most important thing is, a life on welfare is a life of poverty. The only way to get people to move out of poverty is to get them in the world of work to move up the economic ladder.

I think a lot more needs to be done with the proposal that we passed in 1996. I am particularly troubled that a majority of adults receiving assistance report that they are engaged in zero hours of work or work-related activity. That is contrary to the goals of 1996. I am also concerned about the way that the caseload reduction credit has functioned.

As you know, when States reduce their welfare caseload they receive a credit towards their work participation program. States are currently required to meet 50 percent participation.

Nationwide, the welfare caseload has dropped over 50 percent. This means that, because States can capture a 1 percent credit towards their participation rate for every 1 percent reduction in caseload, many States actually have zero participation requirements.

I am concerned that the caseload reduction credit has effectively undermined the real participation rate. Could you comment on whether or not you believe that establishing a real participation rate for States is a fundamental reform that must be included in the reauthorization?

Secretary THOMPSON. Absolutely. I applaud you, Mr. Chairman, for putting a floor of 50 percent. That was really, I think, the original intent of the legislation passed in 1996. But because States were so successful in reducing people off the caseload, it was reduced on a percentage-by-percentage basis.

So what ended up, is States like Wisconsin really do not have any particular reason to advance anybody else to work because they do not have any requirement under the law. The caseload reduction has worked in opposition to accomplishing the objective of the original bill, and that is encouraging people to go to work.

Therefore, your floor of 50 percent which you put in that was passed by the Senate Finance Committee is a giant step forward. I applaud you. I think it is the right thing.

It is going to be very important for us in the administration, and for you as Senators, but also for Governors to work to continue to push, to urge individuals to take the courses necessary, to get the training necessary, to get off of welfare and get into work. Because you said it, you cannot get out of poverty unless you work.

The current system is locking people into poverty. We want to be able to emancipate them and give them the opportunity to get the training necessary to get out. A 50 percent floor is going to be an inducement to do that, and I applaud you.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Secretary, I would just like to get to this point about the differences between the two bills and what we do in the future so we do not have this problem again.

Secretary THOMPSON. Yes, please.

Senator BAUCUS. I believe that the legislative language should be passed essentially codifying that 1997 Balanced Budget Act lan-

guage which, in effect, says that actuaries' estimates, the assumptions, will be available to the public and to Congress. What is wrong with that?

Secretary THOMPSON. For me, personally, nothing. But let me just expand a little bit.

Senator BAUCUS. Not too long. We have got five minutes and I have got a lot of questions. Get to the point.

Secretary THOMPSON. But you said that I was not forthcoming and I take umbrage to that, because I am very forthcoming. Any time you call me, Senator Baucus, I respond to you.

Senator BAUCUS. You have. You have, very much. That is true.

Secretary THOMPSON. Very much so.

Senator BAUCUS. That is true.

Secretary THOMPSON. I talked to Tom Scully. He was supposed to get that information. I know that information on the actuaries was given to CBO scorers.

Senator BAUCUS. That is not my understanding.

Secretary THOMPSON. Well, it certainly was.

Senator BAUCUS. The assumptions. We were talking about the assumptions behind them.

Secretary THOMPSON. The assumptions. The assumptions were changing, as you know. You were in the meetings right up until the end. The assumptions were changing right up until the end. Two days before we passed the Medicare reauthorization out of the committee, there was a score of $360 billion. The committee decided to spend an additional $35 billion and our actuaries had no input whatsoever.

The second thing is, the dual eligibles were taken over in the last 12 hours of the conference committee. That had a change of several hundreds of millions of dollars that adversely impacted upon the score.

Senator BAUCUS. Well, let me put it this way.

Secretary THOMPSON. And all of those things were done. As a result of that, we did not get the final score until the 24th of December from our actuaries. We made it available to OMB at that time.

Senator BAUCUS. All right. The real point is, it is a huge difference. During all of our discussed in the conference, this was never raised by the administration of a number anywhere approaching this magnitude. Never. It was never raised in the room. Never.

During our discussions in the conference room, I, many times, was baffled by the variations in estimates. I asked the administration—I asked CBO, but particularly the administration, you were there, and others—what are your assumptions and what explains even the differences then we had on participation rates, for example? What are the HHS actuaries' assumptions that caused this different conclusion? Eyes glazed. Nobody would answer it.

At the same time, my staff would be calling constantly over to HHS and the actuaries trying to get the same information. We were given information only in one area, and that is on plan participation rates. That is only about 20 percent of the cost differential. Then beyond that, we were not given access to the actuaries unless a White House person was on the phone or unless another policy person was on the phone. We did not have direct access to

the HHS actuaries. We did not. We were prevented from having access so we could not ask the questions.

That leads me to the conclusion that the administration is hiding something or they are trying to manage too much by themselves, and the poor actuaries are kind of being taken advantage of. Professionally, they feel very bad about this. So all I am saying is, in the future, we cannot let this happen. What I want is good government here.

Secretary THOMPSON. So do I.

Senator BAUCUS. May I finish, please? And good government, to me, is having the facts out on the table, the HHS actuarial facts, as well as CBO. We go by CBO numbers, and I think in the perfect world CBO needs a check. Somebody has got to check CBO to make sure they are coming up with the right figures. In this case, the right agency would be HHS.

But HHS was prevented from doing so, in the sense that we could not get the assumptions behind HHS information. That is just wrong. It is contrary to the 1997 report language which says that we should. It is contrary—by far, contrary—with past practices.

In the last 10 years, the Congress has had access to actuarial estimates and their assumptions. But this administration has blocked us. I think it is wrong. In fact, it is so wrong, I am introducing legislation to stop it. So, for good government, we get information out on the table. As I said earlier, it is not a policy matter. It is not a partisan matter.

We are just getting the facts out on the table so that Congress and the administration, together, can decide what the correct policy should be. I just want to work with you. I think you would agree with me that that should be the result. If you disagree that that should be the result, I would like to hear that.

Secretary THOMPSON. No, I agree with you.

Senator BAUCUS. So you will work with us in getting legislation passed.

Secretary THOMPSON. But, Senator Baucus, I really want to point out that the CMS actuaries did not have this thing completed on the 24th. The participation, we did. Our participation, you knew, and everybody else did in the conference committee, was different than CBO.

In fact, several members of the conference committee said we will use CMS actuaries as it relates to participation, but the CBO score will have the best of both worlds. That was mentioned during one of the conference committees. There was also a lot of information given.

But in regards to the final assumptions, the total amount was not brought to my attention, was not completed by our actuaries, until the 24th of December.

Senator BAUCUS. That is the first you heard of this?

Secretary THOMPSON. That is the first.

Senator BAUCUS. The $530 billion, whatever it is?

Secretary THOMPSON. The $534 billion. If I could quickly go through those figures, there is a big difference. In Part B, 91 percent of the people—which is a voluntary program, as you know—

participate. CBO estimates that under Part D, the new drug benefit, it is going to be 95 to 96 percent.

Our actuaries think that participation is going to be 99 percent. That is a difference of $50 billion right there out of the $139 billion. Over one-third of it is on that figure alone. Nobody knows. You do not know, I do not know, our actuaries do not know if it is going to be 95 or 96 percent participation, which is what CBO is saying, or the 99 percent.

Senator BAUCUS. Then that is all the more reason for my point.

Secretary THOMPSON. All right.

Senator BAUCUS. That is why all of that information has got to be out on the table for the public so that we in the Congress here have a much better idea which assumptions are most valid so we can make a choice, a decision.

Secretary THOMPSON. But I know the participation——

Senator BAUCUS. You are fuzzing it up.

Secretary THOMPSON. No, I am not.

Senator BAUCUS. I am talking about the general principle, should, generally, this information be made available and should Congress have access to those making these estimates, and the assumptions that they are using in making their estimates. We have not been given access to HHS actuaries and the assumptions that they are using during the writing of the Medicare bill.

I have taken way too much time. I thank you.

Secretary THOMPSON. Thank you.

The CHAIRMAN. Senator Kyl?

Secretary THOMPSON. I would just like to say that the assumptions on participation were given to a lot of individuals. If you did not have it, I am sorry.

Senator BAUCUS. I am sorry. That is only 20 percent of the bill. I am talking about the other 80 percent of the bill.

Secretary THOMPSON. And I am telling you that the last 24 hours of the Medicare bill, a good share of that was not finished up by our actuaries until the 24th of December.

The CHAIRMAN. Maybe if there is a misunderstanding on this we ought to sit down in private and try to iron it out.

Secretary THOMPSON. I would be more than happy to.

The CHAIRMAN. Senator Kyl?

Senator KYL. Yes. Thank you, Mr. Chairman. I agree with that. I do not mean to prolong this, but I think that we should not leave some misimpressions here.

Why on earth would it be in the administration's best interests to deliberately hide a high number here? Why would the administration want the number to be higher than the CBO number? It does not make any sense. There could not be any deliberate misleading, or as Senator Baucus said, the administration might be hiding something.

Second, for those who were not in the room, as I was, we constantly asked for the administration's position. Tom Scully told us more than we ever wanted to know about the actuarial assumptions of the administration, to the point that a lot of times we cut him off and said, that is fine. But we are bound by the CBO numbers, so that is what we have to go with.

I just do not want anybody to get a misimpression here that somehow or other the administration's spokesmen, when they came before us, appeared to be hiding anything. We got all the information, at least that I thought that I could get from them.

The Secretary is quite right. We made huge changes in the last few hours of the negotiations and, in effect, had to wait for the CBO score to move forward. Clearly, the administration obviously was not involved in the discussion there. So, let us not have a misimpression left here that somehow or another the administration was hiding something.

Mr. Secretary, I have two main concerns. There are more and more stories about safety concerns associated with the reimportation of prescription drugs from Canada. I just wonder, given the fact that there are increasing calls from some State governments to import drugs from Canada or other countries, whether you could shed some light on these safety concerns, the magnitude of their concerns from your perspective.

Secretary THOMPSON. Thank you very much, Senator Kyl. As you probably know, the FDA has done two stops in which they took over some of the drugs that were coming into America. The first time was the latter part of July. Seventy-five percent of those drugs had something wrong with them.

They either were packaged wrong, they were not refrigerated—like, insulin has to be refrigerated—there were some wrong drugs, some counterfeits. Some came from countries different than what the label said. So, that was three-quarters.

We just had another operation in which we stopped the same, and it was pretty much the same. Seventy-five to eighty percent of the drugs coming in that were stopped were somehow erroneous compared to the package that they were in, or were not the right drug for the package, or the right doses.

Senator KYL. And that could be very dangerous to people then relying upon the information.

Secretary THOMPSON. It could be extremely dangerous. That is why FDA has taken such a strong position on that.

Senator KYL. I think it is an important point. If we can get all upset about something like the Alar scare of several years ago, it seems to me that this is a much more serious proposition than that.

Secretary THOMPSON. If you would like that information, I can get it written up.

Senator KYL. Mr. Secretary, it would be good, I think, for the committee to have that in writing. If you could provide that, that would be great.

Secretary THOMPSON. I would be more than happy to submit that.

Senator KYL. Thank you.

There is a provision in the bill that precludes the Federal Government from directly trying to influence the pricing negotiations between the various entities that are going to be purchasing the drugs and the various prescription drug companies to interfere in these price negotiations.

I just wonder if you could elaborate on the consequences that you see that might arise if the government were permitted to directly involve itself in those price negotiations.

Secretary THOMPSON. Well, we would be purchasing, Senator Kyl, such a huge amount that we would have a tremendous impact on the market. We could drive the market down or drive the market up with our purchases, pretty much. That has always been a concern of the Congress, in giving the Secretary that kind of power.

Senator KYL. Thank you.

And just very quickly, for my own edification, the total budget, $580 billion in outlays, represents a 5.9 percent increase over last year. Correct?

Secretary THOMPSON. That is correct.

Senator KYL. Of that, $67 billion is in the discretionary portion of the budget. That only increased 1.2 percent. Is that correct?

Secretary THOMPSON. That is correct.

Senator KYL. I do not have the number here, but we would understand from that that the non-discretionary part increase was substantially above 5.9 percent. Do you have that number?

Secretary THOMPSON. I do not, but I can get it for you.

Senator KYL. All right. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Yes. Thank you very much.

Secretary THOMPSON. But the mandatory is so much higher than the discretionary. It is $580 billion versus $67 billion. So, it is not going to have much change.

Senator KYL. So it might be somewhat over 6 percent, but not much.

Secretary THOMPSON. About 6 percent.

Senator KYL. All right. Thank you.

The CHAIRMAN. Now we go to Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. Thank you for having the hearing, even if we had to move it over to the House side. I spent a lot of time over here and got a lot of memories, none of which I can remember, which is probably a good thing that I do not. [Laughter.] But I am glad to be over here and am glad the Secretary found the location.

One of the arguments has been the costs of the program. It is really interesting to debate. I mean, many folks on my side were advocating that much more money be spent on drugs than the $400 billion we thought we would be looking at.

Now as the price goes up, there is a lot of debate and argument about, well, if we had done it differently, it would not be so costly. One of the suggestions is that if we had just not taken the language prohibiting the government from negotiating the price of the drugs, the program would cost less.

That proposal has been around a long time. Many on my side of the aisle, in Democratic versions of legislation, have always prohibited the government from directly negotiating on the price. But it seems to me, with the structure of the bill that we had, it would not make any difference whether the language was in there or not because the delivery system we have is not the government buying drugs and delivering a drug.

We have created a private delivery system whereby private companies negotiate for volume discounts and for the use of various formulas to bring down the price. Whether we had the language in the bill or not saying that the government is not allowed to negotiate the price of drugs, it seems to me, would not make one iota of difference either way, because the fact is, government does not negotiate, sell, or buy the drugs under the Medicare bill we just passed.

Can you comment on that?

Secretary THOMPSON. I can comment on it, but I think you have pretty much summarized it.

Senator BREAUX. I mean, do you agree with that?

Secretary THOMPSON. Yes, I agree with you. Absolutely. That is the reason that you and the other members of the conference worked so hard to come up with a bipartisan proposal on this particular subject.

That is to allow for insurance companies, the private sector, to be able to negotiate with the drug companies in order to get the best price so that they can deliver that to their members.

Senator BREAUX. In fact, is it not true, I do not remember whether it was CBO or OMB, or maybe a third party, had actually said the fact that we would get more savings through this type of negotiation than we would if it was the government negotiating it.

They compared it to the government negotiated prices by the States under the State Medicaid programs and they said that this, in fact, would deliver a better price. Is that your understanding?

Secretary THOMPSON. That is the assumption, and I believe it is a correct one, Senator Breaux.

Senator BREAUX. Let me ask, how are we doing on the drug discount card? I mean, the only thing that is going to happen this year that is going to affect directly the average Medicare patient, is they are going to get a drug discount card sometime this year.

It is going to give them the ability to purchase drugs at a substantial reduction over the price they pay now, number one. In addition, if you are poor, you are going to have a $600 credit that you can use off of that card.

My question is, do we have an idea now of how that discount card from the Federal Government is going to interact with the discount cards that many of the pharmaceutical companies have already in existence?

A number of the companies have discount cards if you buy their product. If you can, just maybe in general terms, is a senior going to have multiple discount cards or would they have one Federal card, or what?

Secretary THOMPSON. They are going to have the opportunity to have multiple discount cards, and it is going to be one of competition. We had an application for request for proposal that had to be in by the end of January.

We had several applicants. By the end of March, I believe, between March 15 and March 25, we are going to make our recommendations as to which companies, which entities, which nonprofit organizations are going to have the opportunity to issue these cards. We will be making that available.

I met last night with, I think, 18 different groups who want to go out, including AARP, and make sure that individuals know everything they can about the card. They also want to be partners in enrolling individuals so everybody that is capable and is eligible is going to be able to get it.

They also want us to use the LIHIB computer dates that we have in order to see if we can get a faster start for those individuals that will qualify for the $600 subsidy. So, all these things are in the works.

Senator BREAUX. My point would be that it is very important to try and minimize the potential confusion. I mean, if a senior has 10 discount cards, one from the government, one from company A, B, C, and what have you, and they are going to be going to that drug store saying, which card do I use here for the discount—

Secretary THOMPSON. We are going to have that all straightened out.

Senator BREAUX. The ideal would be if you had one discount card that, through computers, could incorporate every company's card with the Federal card. I am not sure that is possible. But to the extent that we could minimize the confusion to seniors using that discount card, I think, is very important.

Secretary THOMPSON. I will give you all the information when we get all the applications in and tell you the direction we are going to go, Senator Breaux.

Senator BREAUX. All right.

The only other thing I would mention, is one of the things I disagreed with in the bill was the health savings accounts. I mean, I think that HSAs really have very little to do with Medicare and a great deal more to do with tax shelters. It is an unprecedented tax shelter in the sense that the deposits are tax-free, the interest you get is tax-free, the funds that you generate are tax-free.

The President's proposal apparently says that even the premiums that you would pay for a high-deductible insurance policy would be made tax-free, too.

The concern I have always had, is that does not do very much for Medicare. It does a lot for young people, but not a lot for old people are not going to be buying high-deductible policies. That is in there. I wish it was not, but it is a fact. So, thank you.

Thank you.

The CHAIRMAN. Thank you, Senator Breaux.

Now, Senator Thomas.

Senator THOMAS. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for all the good work. I am certainly very pleased with what has been done. I have a special concern about rural health care, and I think it has been treated very well here.

But I would like to deviate and just ask for a general reaction. As I go around now in our State and talking to people, the thing I hear most about is the cost of health care and the cost of health insurance for everyone.

We have focused here on Medicare and Medicaid, as we should. Now we need to take a look at what we do for the total population here on health care. What in this proposal this year will be your efforts to deal with the cost of health care, generally?

Secretary THOMPSON. Several things. Number one, I think we should really put in a tremendous emphasis on interoperability of computers. Right now, we are practicing medicine still the old-fashioned way. We still use everything in writing. We still use everything in folders.

What we are trying to do, and under the President's proposal we are going to have $50 million set aside for demonstration programs for patient safety. In regards to ARC, we are also putting $50 million in the Secretary's office in order to put demonstration programs out.

We are also putting out a new program called SnowMed, which we licensed from the podiatrists, which has all of the lexicon of the maladies and the treatments. We are going to give that free of charge to all clinics and doctors so that everybody will have uniform language dealing with medicine.

We have also contracted with the Institute of Medicine to sit down to have uniform patients' records, so we are going to be able to have a patient record that is the same in Wyoming as it is in Wisconsin, as it is in Iowa, as it is in Texas.

We are going to be able, hopefully, then to transfer and transpose the way we practice medicine towards a modern computer-type system that we think is going to drive down. We think there can be tremendous savings.

The second thing is, we wanted to address the uninsured with tax credits. We think we can do a little bit better in regards to the tax credits by asking States to set up a voluntary pool of all those that are uninsured, to be able then to set up an insurance commission or commissioner to be able to take the tax credit to set aside for Wyoming, be able to apply for a proposal from insurance companies that they would bid on it. It is going to be a very good, insurable market because so many young people are going to be in this market. It should be very insurable.

If you take the collective tax credit for a particular State and apply that, you are going to be able then to get a lot of people to buy into it and use the tax credit and maximize those individuals that are going to be qualified.

The third thing we want to do, is we want to really get to patient safety. We are putting out demonstration programs because up to 98,000 people die each year from mistakes made in hospitals and clinics.

We have got some demonstration programs where we are going to utilize the system, through the Department of Health and Human Services, to try and maximize better safety things in regards to health insurance.

Those three things are going to be great moves towards reorganizing medicine and hopefully holding down on costs in medicine, and improving the quality of medicine.

Senator THOMAS. Thank you, sir.

Secretary THOMPSON. I probably gave you more than you wanted.

The CHAIRMAN. Are you done?

Senator THOMAS. Yes, Mr. Chairman.

The CHAIRMAN. All right.

Now we go back to the Democratic side. Senator Bingaman is the next one up.

Senator BINGAMAN. Thank you very much. Thank you, Mr. Secretary.

A lot of us had concern last year when you submitted your budget that there was a proposal by the administration which we interpreted as a proposal to block grant Medicaid.

Secretary THOMPSON. I know.

Senator BINGAMAN. This year, you talk in the budget document about wanting to work with Congress to pass an option for States to receive Medicaid funds in the form of flexible allotments.

I am concerned that this may essentially be the block grant proposal in different clothing and that, in fact, what you are proposing here is to negotiate with States to cap what they receive from the Federal Government in Medicaid in exchange for them getting certain flexibility with regard to inter-governmental transfers and other items.

Could you explain what you are asking Congress to do and what you are trying to do on your own in this area? Because I think Senator Baucus raised the question as to whether you were using the waiver authority that is already in the law in ways that it was never intended to be used.

Secretary THOMPSON. Well, I disagree. I think I comply with the law in everything I do. I have been very aggressive in waivers, and will continue to do so because I think I have been able to show where I have been able to use the waiver process where 2.5 million Americans have been able to get health insurance that would not have it now.

We have been able to expand benefits to 7.5 million Americans that would not have it without the waiver process. We have no backlog at all on waivers. We are up to date as far as State plan amendments and waivers.

We have had the permission, and we have also gone to every State that we granted a waiver to, and asked the Congressional delegation, as well as the Senators whether or not they supported it. We do that on a regular basis. We will continue to do so.

In regards to Medicaid, I strongly believe that we should modernize Medicaid. I think there has got to be some tremendous changes. What I am saying in that proposal, Senator Bingaman, is I want to sit down with Governors, I want to sit down with this body and try and find ways in which we can modernize Medicaid.

The Medicaid system right now is one in which States are pulling away from their responsibilities big time because of the financial problems they are having. I think there were 42 States last year that cut back on Medicaid.

I am trying to modernize it and give them the flexibility so they do not have to withdraw, that they will be able to use the Medicaid system to continue to fund, continue to apply that to the people that need it.

I disagree with you that it is a block grant. It is not. What I am trying to do is provide for flexibility so that States like New Mexico, which is different than the State of Wisconsin, will be able to use that flexibility to adapt a Medicaid program that is more conducive to the people in New Mexico than to a united system. That is what I am trying to accomplish, Senator.

Senator BINGAMAN. Well, obviously I favor flexibility. I am not interested in seeing the Federal Government cap what it provides to States under Medicaid, and do so even if it does so with agreement of the States in order that the State gets other flexibility in the process. It seems to me we should give them the flexibility without requiring them to live under a cap.

Secretary THOMPSON. Well, the cap last year was an adjustable cap in which it was still allowed to grow at the rate of 9 percent a year, which was the line of growth that it was with or without a cap. That would not change.

Of course, you know that a cap cannot be placed upon it unless on a bipartisan basis or unless Congress approves it, which I doubt very much is going to happen. So, I am looking at other ways other than a cap to be able to support increased flexibility for Governors and States to administer their Medicaid programs more efficiently, and that is what my goal is. I would love to work with you in order to accomplish that, Senator Bingaman.

Senator BINGAMAN. Let me also ask about the global fund for HIV–AIDS, tuberculosis, and malaria. You are the chair of that fund.

Secretary THOMPSON. Yes, I am.

Senator BINGAMAN. As I understand it, the fund will need about $1.6 billion in 2005 to keep current projects going. The Congress has authorized up to one-third of those contributions to the fund to come from the U.S.

Secretary THOMPSON. That is correct.

Senator BINGAMAN. And as I understand it, you have asked for $200 million.

Secretary THOMPSON. That is correct.

Senator BINGAMAN. Why have we not asked for the third?

Secretary THOMPSON. Well, because we are already above the third, Senator Bingaman. The United States has given more money than the third right now. Right now, the $200 million qualifies for the one-third, because anything more than that, the other countries have to give more money or else we will be above the one-third cash involvement for the global fund. That is the reason.

Senator BINGAMAN. So you believe that the $1.6 billion that is needed to keep current projects going will be there this year?

Secretary THOMPSON. Let us just say we have been in operation about 30 months, and we have raised a total of about $4.7 billion. We are in 124 countries, and 225 projects in those 124 countries. We have been able to meet our obligations to date, but right now every year is going to be a struggle because every year more countries are applying it.

But there is a statutory restraint put on by Congress that says the United States cannot contribute more than one-third of the cash towards the global fund. Right now, the United States is about 38 percent of the cash to the global fund.

So, even if you would appropriate more money, the United States cannot advance that money, or the global fund cannot receive it unless we get more donors and more contributions from the other donors. We are above the one-third limit that this Congress has set.

Senator BINGAMAN. Do you think we should eliminate that limit?

Secretary THOMPSON. Not at this point. I really think what we need to do, and what I am trying to do as the chairman, is I have traveled quite a bit and I am giving speeches around the world encouraging other countries to contribute.

This was not set up just to be a United States fund. We need help from other countries and other countries have not, I think, advanced as much or done as much as the United States.

I think, when we started out, the United States' original intent was about one-fourth to one-fifth of the dollars of the global fund. Then the Congress passed the big AIDS bill and put a limit of one-third on it, Senator Bingaman, and we are currently above that one-third in the global fund.

The CHAIRMAN. Senator Bingaman, I would like to move on to the next question.

Senator BINGAMAN. All right. Is my time up, Mr. Chairman?

The CHAIRMAN. Yes.

Senator BINGAMAN. All right.

The CHAIRMAN. Also, I would like to announce, since we are not in our offices, that I will keep the record open longer than the normal time. Right now, I had set 1 week for people to submit questions for answers in writing.

If we do not get into our offices, planned by the forecasts thus far, then we will extend it to a later period of time, so people will know they will have ample time to submit questions for answer in writing.

Senator Hatch?

Senator HATCH. Mr. Secretary, I, for one, am very pleased with the efforts that you have made ever since you have been Secretary over this very, very difficult agency to run.

Secretary THOMPSON. Thank you.

Senator HATCH. It has really got the biggest budget of any agency, as far as I can see, in government today. It is almost impossible to run, and you are doing as good a job as I have ever seen done.

Secretary THOMPSON. Thank you, Senator.

Senator HATCH. I appreciate your work on global AIDS.

Secretary THOMPSON. Thank you.

Senator HATCH. There is no question that that is a very important aspect of American compassion, but also very important for the world as well.

And, by the way, those of us who were on the conference committee on Medicare, did not have too many illusions that there would be a difference between the CBO estimates and the final CMS analysis. CMS did not have the figures at that time because Mr. Scully made different assumptions and different suggestions. So, I knew there was going to be a disparity. I just did not realize what it would be. I think most others should have known that as well.

Now, one thing. As the prime sponsor of the CHIP program, I am aware of the Michigan waiver which allows childless adults to receive health care through CHIP dollars.

I am deeply troubled by that decision because the intent of the CHIP program, of course, is to give help to uninsured children who are the only ones really left out in society.

So, I am deeply concerned about providing health coverage to childless adults through CHIP dollars when there are still uninsured children in our country who qualify for the CHIP program.

So, I do not know what you can do, but I am very, very interested in anything that you can do, and would appreciate it in that particular area.

Secretary THOMPSON. Thank you very much, Senator.

The Michigan waiver was suggested by the Governor and the two U.S. Senators from Michigan. Michigan would have to send that money back in. They had used their allotment for children.

There was an extra amount of money and they wanted to help the lowest individuals in the State of Michigan, I believe, at 30 percent of poverty, down to a couple thousand dollars. I think there are only 33,000 individuals.

Plus, there is a provision that says if there are any children that are uninsured in the State of Michigan, that this waiver is going to be waived. So, there is a protection for anybody that came in that had children. This waiver would be withdrawn.

Senator HATCH. I am also interested in the quality demonstration project in the Medicare law, Section 646. Now, I understand that health care leaders on the quality issue will be meeting with HHS officials sometime in the near future. Dr. Brent James of Inter-Mountain Health Care of Utah, is very involved with that particular project as well.

Secretary THOMPSON. He is great.

Senator HATCH. He is really good in this area.

Secretary THOMPSON. I tried to hire him.

Senator HATCH. I know. We suggested that you should.

Secretary THOMPSON. You suggested very strongly that we should.

Senator HATCH. He wanted to stay in Utah. I do not blame him a bit. Right now, I am missing Utah very badly. But I would appreciate being kept in the loop on that particular matter because it is important to everybody.

Secretary THOMPSON. Very important.

Senator HATCH. One last thing, Mr. Secretary. In light of what has been happening up here for the past few days, I am deeply interested in hearing more details on the disease detection and bioterrorism preparedness. I know that the fiscal year 2005 budget includes $373 million to accelerate detection of disease outbreak.

You also include increased funding for an array of programs, assistance to State and local government, biosurveillance, and construction of biosafety labs. Could you take just a few minutes to talk about these?

Secretary THOMPSON. Thank you very much, Senator.

But, first, let me comment on the demonstration programs. As you know, I am extremely passionate about this because I think we have a chance to really start managing diseases in America. If we do that, we will do a better job of holding down costs.

The preliminary physical, I think, is one of the best, if not the best thing in the whole Medicare bill, from my point of view as Secretary of Health and Human Services.

In regards to bioterrorism, I wish you, Senator, and every member of this committee would come over to the Department of Health

and Human Services and see what we have done to set up a war room, a communication room. I see some people nodding in agreement.

We have a place that is visionary that tracks diseases and bioterrorism activities all over the world. Secretary Rumsfeld has been down, Vice President Cheney has been over.

I would encourage all members of this committee, if they have the time, to stop over and see it. I think, once you walked out of there, you would be absolutely amazed what we are doing to protect America against bioterrorism attacks, as well as any kind of infectious disease. I hope you would avail yourself and come over and do that.

Senator HATCH. Well, thank you, Mr. Secretary.

Secretary THOMPSON. In regards to the $135 million, what we are trying to do is, right now we get laboratory analysis, but what we are going to do is we are going to expand that into the clinics and into pharmaceutical stores and into nurses' hotlines so that we get information, so that if we see in one area, say, Utah, that there is a huge increase in the purchase if Cipro or doxycycline, we would then be able to know immediately that particular day that there may be a new disease in Utah. That information will be collated through our big computers down at CDC headquarters in Atlanta.

That will then be shared with the Secretary's office and with Homeland Security and we will be able then to make a determination if there is something on reel or something that needs to be taken care of right away. We are going to have this information, hopefully, set up by the end of this year if, in fact, we get the appropriation.

The CHAIRMAN. Senators Nickles, Graham, Lincoln, and Conrad, would be next.

Senator Nickles?

Senator NICKLES. Mr. Chairman, thank you very much.

Mr. Secretary, thank you. One, I want to thank you for including me on your global AIDS trip to Africa.

Secretary THOMPSON. Thank you.

Senator NICKLES. That was a very enlightening, troubling trip. Educational, to say the least.

Your discretionary spending of $67 billion, how much of an increase is that from 2001? Did you have that figure?

Secretary THOMPSON. About 26 percent.

Senator NICKLES. So discretionary spending in the last three or 4 years has gone up 26 percent.

Secretary THOMPSON. Correct.

Senator NICKLES. And this year you have proposed 1.2 percent.

Secretary THOMPSON. 1.4 percent.

Senator NICKLES. All right.

Also, I just want to make a couple of comments on the estimates in the prescription drug proposal. CMS is much higher than CBO, but correct me if I am wrong. If my memory serves me, I think, on occasion, there were a lot of things that were put in the bill the administration did not want, one of which was the Federal Government picking up Medicaid.

Secretary THOMPSON. That is correct.

Senator NICKLES. Or assuming Medicaid. I will tell my colleagues, I think you were right on that. We lost in that debate. We tried. All States have fiscal crunches right now, and all States held down, or tried to hold down, their Medicaid costs.

Some States had limitations on prescription drugs, for example, three drugs per month. Those limitations are going to be erased in many cases now and the Federal Government is going to be picking up a lot of that liability.

I think the estimates are going to greatly exceed even what CMS has. I have always thought that that particular portion is going to be very expensive. So, that was one of the provisions.

The administration also said, as far as competition, you wanted to limit it to three bidders. We did not buy that. You were saying that that would save a lot of money and make people really drive down their costs to be competitive to make sure they were one of the winners. We did not do that. You tried very hard, but you were not successful. So, that had to have a big difference.

Your actuaries were always saying that makes a difference. CBO's actuaries were saying they did not give it that much differential in cost, and we all knew that we were going with CBO. There was also a reduction at the last minute—over my objection, and I guess the administration's, I am not sure—on lowering the deductible.

The deductibles were almost cut in half for the lowest of low income. I think we had it at $2 and $5, and it went to $1 and $3. That was a last-minute deal. That could not have been scored by CMS because it was put in at the last minute. That will greatly increase utilization. If people do not have to pay anything, it is going to increase utilization.

Now, maybe you can correct me on the percentage, but the very generous benefit, the low-income benefit, would apply to what percentage of Medicare?

Secretary THOMPSON. One-third of 40 percent.

Senator NICKLES. I was going to say, I was thinking 38 percent. But I am, again, stretching my memory from a couple of months ago. But 38 percent or somewhere in that neighborhood, to have to pay as little as $1 to $3, or maybe $5, with no donut hole, no limitation, that is going to be a very expensive provision.

I believe you estimated that participation would be much higher. Certainly in those income categories, it would be much higher. I can see how this thing can get very expensive. Also, there is an increase in employer subsidy added on at the last minute.

CMS estimates the per capita cost is 7 to 10 percent higher in the first couple of years than CBO. Is that correct?

Secretary THOMPSON. That is correct.

Senator NICKLES. Do you have that per capita cost figure?

Secretary THOMPSON. I can get it. I do not have it.

Senator NICKLES. If you would give that to me, I would appreciate that.

So, I just wanted to make those editorial comments, that a lot of people worked to expand the scope and the cost or the benefits in every way imaginable, and it should not be a surprise—to some, but it does not surprise me—that the cost exceeds some estimates. I have always been concerned about this. I compliment everybody

who was involved in the negotiations, but a lot of very expensive provisions were added in.

Secretary THOMPSON. About $45 billion from our actuaries, Senator Nickles, is for low-income, more utilization, as you have indicated. Of the difference of the $139 billion from CBO versus our actuaries, $45 billion of it was for a much faster and bigger increase as far as the low income.

Senator NICKLES. I appreciate it. If you could give it to us pretty detailed.

Secretary THOMPSON. I can.

Senator NICKLES. We asked it from CBO. But, if you could, give us a detailed explanation of the differences of the assumptions. You are going to be testifying before the Budget Committee, I believe, next week.

Secretary THOMPSON. I will have it.

Senator NICKLES. I am sure this will come up again, and it would be helpful for all just to kind of have a comparison of the differences.

Let me just switch to one other issue. That is an area that I believe there is still a lot of waste in, and that is in Medicaid intergovernmental transfers. I think there is a scam, a scheme, or fraud. It bothers me. A lot of States are doing it.

Could you give a brief explanation of the fraud and how you plan on closing it down?

Secretary THOMPSON. As you know, the law allows for State governments to use the costs of local units of government to meet their match. But what we are seeing more and more frequently, is that the States are getting a refund, so the States are not using their own dollars.

As Medicaid was set up on the basis of 50/50, 60/40, whatever the State match is, but the States and local units of government have got to utilize at least 40 percent of their dollars in order to meet the Federal match.

What is happening on a more regular basis, is the States, because of the financial problems they are having, are charging a tax to the local units of government, using those tax dollars then to draw down more money, then refunding the tax back to local units of government so there is actually no money.

What they are doing, is they are using dollars from the local units of government through the State government to draw down more Federal dollars with no input, no infusion of State and local dollars. What we are trying to do is prevent that.

Senator NICKLES. I appreciate my time is up. For the Budget Committee, I would like to get into this in a little more detail, so you would be prepared for that.

Secretary THOMPSON. Sure.

Senator NICKLES. But the net result of it is, instead of the State having a percentage, the 40 percent or something that they would normally pay, it is basically 100 percent federal.

Secretary THOMPSON. It could be 100 percent. It could be, instead of 40 percent, 30 percent, or it could be 25 percent.

Senator NICKLES. It could be even greater than 100 percent.

Secretary THOMPSON. It could be, because you could draw down more Federal dollars without any input from the State. But usually

it is not a complete, 100 percent. But instead of 40 percent, it is less than 40 percent, therefore, it is not fair to the Federal taxpayer.

The CHAIRMAN. Senator Graham, Lincoln, then Conrad.

Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman. I also want to thank you for your willingness to hold a hearing on the issue of the prescription drug and Medicare Reform Act so that we can get into these issues in greater detail than our 5 minutes will allow us to do it today.

The CHAIRMAN. I have not worked that out with Senator Baucus yet, but I just assumed, without even talking to Senator Baucus, that with a new program coming on board we need some opportunity to make sure that it is being administered according to Congressional intent, and working out.

Go ahead. Start Senator Graham's time right now, 5 minutes. It had run down. I used up some of your time. I am sorry.

Senator GRAHAM. That is, typically, generous of you, Mr. Chairman. I appreciate that very much. A man from the soil of Iowa.

The CHAIRMAN. Thank you.

Senator GRAHAM. Mr. Secretary, I do want to ask some questions about the prescription drug Medicare reform bill.

According to the analysis that has been done, approximately 20 percent of the explanation for the difference between the $395 billion and the $530 to $535 billion comes from the Medicare Advantage program. The CBO had estimated that there would be 9 percent participation in the Medicare Advantage. The White House is estimating 32 percent participation.

I would have thought that the higher the level of participation, the lower the total cost to the program would be, but rather than that, for each additional percentage point of participation, as an additional cost of the program of approximately $1.4 billion.

Why does the White House estimate that, by putting more people into the private plans, which as you indicated have as their goal to lower the cost and get the most efficiency for beneficiaries, that it is going to cost the taxpayers $1.4 billion for every percentage point?

Secretary THOMPSON. Senator Nickles alluded to that when he was asking me a question. The administration wanted the plans to be reduced to the lowest three, so you would force the insurance companies, the HMOs, or the PPOs to come in with the lowest price.

In order to get the market, you would have to have one of the three lowest bids. Our actuaries believed at that time it would be somewhere between 95 to 98 percent of the fee-for-service program run by the government.

On a bipartisan basis, when the conference committee expanded that, our actuaries believed that there was not the compression that will hold down, and as a result of that the increase with more bidders in with no restriction of being the bottom three, will have a tendency to drive up the price, and that is the difference.

Senator GRAHAM. So is the administration going to recommend some means by which this goal of increasing participation by the private plans will not further bloat the cost to the taxpayers?

Secretary THOMPSON. Well, the administration believes that the competition, in and of itself, is going to drive down the prices.

Senator GRAHAM. Well, that does not square with—

Secretary THOMPSON. That is not what the actuaries think. That is our position, sir.

Senator GRAHAM. So you disagree with the White House actuaries?

Secretary THOMPSON. They are our actuaries, so I cannot disagree with my own actuaries. But I can tell you that we believe that competition is going to drive it down. We figure that it would have been the three lower plans, Senator Graham, that we would have had a lower—

Senator GRAHAM. The President has indicated he does not want this bill reopened, so I assume he does not want us to revisit the question of the number of plans.

Secretary THOMPSON. The administration would rather not have this bill opened up this year.

Senator GRAHAM. In our opportunity to submit questions, I am going to ask a question.

Secretary THOMPSON. Sure.

Senator GRAHAM. If you could, explain in detail why you have a different view of the impact of increasing participation in private plans on the total cost to the program because, as I say, it represents over 20 percent of the difference between the original $395 billion and the $530 billion that is currently being projected.

Second, on the issue of negotiation, I think you said, in answer to a question, one of the reasons the administration was opposed to negotiation was because they felt that it would really be the equivalent of price controls on the prescription drug industry.

Last Veteran's Day, I worked at the VA clinic in Miami. I spent a lot of my time in the pharmacy. The pharmacist there told me that the value of the drugs that they were going to distribute this year, if purchased through normal retail channels, would have been $81 billion, but they had bought that $81 billion worth of drugs for $39 billion.

As you know, the VA potentially could be providing prescription drugs to over 20 million Americans. Would it be the administration's position that the ability of the VA to negotiate for rebates and lower prices should be repealed?

Secretary THOMPSON. No, I do not.

Senator GRAHAM. Why is there a difference between the VA's ability and Medicare's ability?

Secretary THOMPSON. Senator Graham, I think the VA is doing an excellent job. The purchase of Medicare for over 42 million Americans, the purchase of all the things that the Federal Government could do, could have an impact on the market.

Senator GRAHAM. Well, now, as I understand it, one of the goals of putting so much money into the support of corporations which are currently providing prescription drug benefits was to try to hold them in place.

If that is successful, the number of Americans who are actually estimated to be candidates for the prescription drug benefit is under 15 million, which is less than the 20 million-plus who are eligible for VA.

So, I do not understand why the smaller number of Medicare beneficiaries represent a threat to the marketplace through government price control, but providing the VA with authority which has, in fact, resulted in more than a 50 percent rebate is not a threat. What is the difference?

Secretary THOMPSON. Basically, there are 42 million Americans that——

Senator GRAHAM. But we just put billions of dollars in this bill——

Secretary THOMPSON. We have.

Senator GRAHAM [continuing]. To try to hold in place the corporate support. Also, some of that 42 billion are getting their prescriptions today through things like Medicaid. There are only about 15 billion in the target group of uninsured.

So, there are fewer people in the Medicare target group than there are in the VA group, yet we accept the fact that the VA should have the authority to negotiate the lower rates, and with dramatic benefit to veterans in America, but we will not provide the same benefit to Medicare. I just do not understand the economics.

Secretary THOMPSON. Well, it is basically one in which the administration believes that we should not have that big of an impact in controlling the marketplace.

Senator GRAHAM. So we could expect the administration to submit legislation to repeal the VA's authority to negotiate?

Secretary THOMPSON. No. I am not going to be advocating that at all, Senator.

Senator GRAHAM. Have you discussed this with Secretary Principi?

Secretary THOMPSON. I have discussed it. Not the repeal. I have discussed his authority and my lack of it.

Senator GRAHAM. I think you just answered the question.

The CHAIRMAN. Senator Graham, we have got two people to ask questions. I think we will not have any problem finishing because we should be done at five after.

But it is the custom in the House, and I suppose we could ignore it since we are the Senate, but since we are guests of the House, they always do not have committee meetings during a joint session of Congress. But I think we can be done at five after, if Mrs. Lincoln goes ahead, then Senator Conrad.

Secretary THOMPSON. Thank you, Senator Grassley.

Senator LINCOLN. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. We are delighted to have this discussion and hope there will be many more.

My concerns, I guess, revolve around the number of working Americans that are uninsured and the cost that it is causing all of us in the health care arena.

I guess I would join with the concerns that many have about the tax credit and whether or not it is the most cost effective approach to reducing the ranks of the uninsured.

I guess my question is, really, that it seems to weaken the employer-based health system through which most of our insured Americans obtain their health insurance coverage to begin with, my concern being that people would have to leave their group em-

ployer-based coverage to use the tax credit in the individual market.

If that is the case, it would probably be most attractive, really, only to the young. Senator Breaux pointed out some of that, the healthy, young employees, because they are able to purchase individual policies for which the tax credit will take up about 90 percent of their costs.

But if the young and the healthy workers opt out of the employer coverage, would the pool of workers then remaining in the employer plans not become really older and sicker, and in that instance really drive up the cost of the employer-based insurance and further raise the amount that we have got for both employers and employees remaining in the plan that they have to pay for insurance?

My concern is we are going to become, again, a disproportionate share there of older and sicker individuals in employee-based plans if all we do is provide incentive to young workers and young individuals.

Secretary THOMPSON. I do not see how they would qualify. They are already eligible for insurance through their employer. This is for uninsured that do not have an employer-based plan.

Senator LINCOLN. But if, in fact, they are able to cover 90 percent of their costs, which is going to be probably more than what their employer is helping them do, they may opt out into a plan like that.

Secretary THOMPSON. I doubt it. I am sure it is possible. But what I am suggesting is that you, in the State of Arkansas, would have the Governor put together a pool of all the uninsured.

Senator LINCOLN. We already have one.

Secretary THOMPSON. Yes. And then allow for the Governor to appoint an insurance commissioner or commissioners to take the tax credit available for the State of Arkansas, and then be able to apply that and put it out for bids.

Then you would have a pool that would allow for many companies to bid on, and the commissioner or commissioners would be able to do it. There would be a connectivity to the tax credit, to those that are uninsured. I think that would be a much faster and more efficient system, embellishing on the President's plan, not my own.

Senator LINCOLN. Including the self-employed, the unemployed in all of that?

Secretary THOMPSON. I would leave that flexibility up to the Governors. But I think that we could design a very good plan for the uninsured in every State in America by using this approach that I have indicated that would allow for the States to have the involvement of setting it up, and then being able to set up a commissioner to look at competitive bids from insurance companies. The State could decide how expansive they want that pool to be.

Senator LINCOLN. A good many States have those already. They do not seem to be working. I do not know.

Secretary THOMPSON. They are not working because they do not have the corpus. I am saying, use the tax credit as the corpus. I do not know the percentage of 100 percent the State of Arkansas represents, but say it is 2 percent. You would get 2 percent of the

total tax credit and you would be able to use that as the dollars in order to negotiate a contract.

Senator LINCOLN. The individual credit.

Secretary THOMPSON. No. You would do it collectively. Then the individual would have a much bigger pool for the opportunity to drive down the bids, and then the tax credits could be used to purchase that.

Senator LINCOLN. Well, one of the things we have been trying to focus on is particularly small businesses, because they seem to be our number one employer, and they also seem to be the ones that have the most difficulty in finding a private product out there.

I am wondering. There is a tremendous amount of money in the President's $70 billion that is dedicated to this. Would it not make more sense to devote some of those dollars towards really being able to collectively bring small business groups together, something we have been working on, to give them a pool to be able to provide insurance?

Secretary THOMPSON. I would like to work with you. I have got a lot of ideas on it. I think that we could use the tax credits as the basis to drive down the uninsured in America. But you have to do it in a collective basis and you would have to allow for Governors to have the flexibility to be able to expand the pool. I would love to work with you on that.

Senator LINCOLN. Great.

Secretary THOMPSON. I have got a lot of ideas on it. I would appreciate working with you on it.

Senator LINCOLN. All right. Thank you.

The CHAIRMAN. Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

Secretary THOMPSON. Thank you, Senator Conrad.

Senator CONRAD. Thank you, Mr. Secretary, for being here. I have enjoyed working with you throughout your tenure in this position.

I want to respond to a couple of things I have heard here. First, I heard Senator Kyl ask the question, what incentive would there be to understate the cost of the Medicare prescription drug bill?

I think the incentive to understate is very clear: the bill would not have passed. Simply a fact. The bill would not have passed if it were known that it cost $530 billion instead of less than $400 billion. That is just a fact.

It would not have passed in the House, in my judgment. I know it would not have passed in the Senate. The budget waiver only passed by two votes and I know it would not have passed in the U.S. Senate if it were known that it cost $530 billion.

That tells me we have got to reopen the bill this year, in light of record budget deficits, deficits as far as the eye can see, deficits that are absolutely going to explode beyond the 5-year window when the baby boom generation retires and the cost of the tax cuts increased geometrically.

So, we are going to have to reopen and we are going to have to find ways to save money in this bill, and we are going to have to find ways to save money across the whole range of Federal expenditure.

I want to associate myself with the questions asked by Senator Graham. I thought they were very powerful and right to the point. These are areas that have exploded in cost beyond what Congress thought was happening and we are going to have to reopen it.

With respect to the other questions that Senator Graham asked, I also believe Medicare, like VA, ought to have the ability to negotiate lower prices. It has worked for the VA, and worked spectacularly. I have confidence in you.

If this authority were given to you, knowing the way you have conducted yourself in public life, I have confidence that you would do it in a way that was fully professional and that would help reduce government expenditure.

With that said, I want to ask you a couple of questions about the bill that passed, and specifically Section 508, dealing with the ability of hospitals to seek index reclassification on a one-time basis. As you know, the wage index has proven to be very difficult across the country.

In some parts of the country we just have really irrational results. In my State, we have a 20 percent difference between hospitals in Fargo, North Dakota and Bismarck, North Dakota. Your hands are tied because they are not contiguous counties, but they are contiguous markets, competing for doctors, competing for nurses, and getting a 20 percent difference. That just makes no sense.

We have addressed it in the bill. You were very helpful, and I thank you for that. I am concerned with what CMS has done with respect to a notice that they published that rendered certain hospitals across the country, and some in my State, ineligible for this one-time reclassification.

I know your staff is aware of this problem. They are working on it. The problem that we are up against, is we have got a deadline, a statutory deadline of applying by February 15 for this relief.

I am told your staff is readying a new notice that would rectify the problems. Can you assure us that will be issued in a way that will permit hospitals to be able to apply by February 15?

Secretary THOMPSON. I certainly hope so. I will give you my word that we are going to work as hard as we possibly can to get it done. I am 95 percent confident that we are going to, Senator Conrad. I do not have complete control over everything, but I would say that you can pretty much rest assured that we are going to get it done.

I would like to thank Chairman Grassley on the wage disparity. It was the first time since I have been a Governor, over 15 years, and Secretary, for 3 years, that we have made some progress. We have been able to reduce the wage disparity from 72 percent to 62 percent. The one person that led this fight for years has been Senator Grassley. I know you support him, and I support him in regards to this thing.

Senator CONRAD. Well, I want to thank both our Chairman and Ranking Member, who were hugely helpful in that effort.

Secretary THOMPSON. Yes. I did not mean in any way to slight Senator Baucus.

Senator CONRAD. I just want to thank you as well, because you were sympathetic in that battle.

Secretary THOMPSON. Absolutely.

Senator CONRAD. Let me ask you this. In terms of these hospitals, it is a handful of hospitals in my State, is it possible that they could apply? I mean, the thing I am very worried about, is they are going to get shut out here, and that would really be a tragedy.

Secretary THOMPSON. Let us get the expert, right here.

Senator CONRAD. All right.

Secretary THOMPSON. Dennis, get up here. Answer it correctly, Dennis. [Laughter.]

The CHAIRMAN. And do not forget Waterloo, Iowa while you are answering that question.

Secretary THOMPSON. We have already taken care of Waterloo, Iowa.

Mr. SMITH. The Senator is correct. The hospitals themselves have to apply by the 15th. We have to have the instructions to them. We met the first date in getting the notice out for the hospitals to apply.

As you point out, Senator, after that rule we have had some issues raised to us that we are reviewing currently, and we can assure you that the notice will get out in a timely way to give them the opportunity to apply. The hospitals themselves obviously still have to make the application.

Senator CONRAD. In a timely way.

Mr. SMITH. So, we will do that in a time-sufficient manner.

Senator CONRAD. And can you give me some idea when that would be done so I can advise them?

Mr. SMITH. We will have it cleared in a timely fashion.

The CHAIRMAN. We can always stop the clock like we do in the Congress. [Laughter.]

Mr. SMITH. Well, we have to meet the statutory deadline of the 15th, and I think we will make that.

Secretary THOMPSON. We are going to do it, Senator Conrad.

Senator CONRAD. I am talking, now, though, about the notice.

Mr. SMITH. Yes.

Senator CONRAD. In terms of, you have got to give the notice before the hospitals can apply.

Secretary THOMPSON. And we will have that out.

Senator CONRAD. You will have it out in a way that is timely. Can you give us an idea of when? I mean, the hospitals have got to apply by midnight on the 14th. The notice has got to be out before that so they can do the paperwork.

Mr. SMITH. I think we would need to have this resolved within the next few days, Senator, so that it can be dealt with.

Senator CONRAD. All right. You are exactly right. It does need to be resolved.

The second thing I wanted to raise, Mr. Secretary, we have told your people about this, but you may not have had time to get briefed on it so I will be fully understanding if you do not have an answer at this moment.

We have had in place a hold-harmless for hospitals that were open from 1991 to 2001 as these hospitals made a transition to the prospective payment system. The policy was designed to help en-

sure that these new hospitals were paid appropriately for capital costs.

Now, for some reason CMS announced it will no longer make hold-harmless payments for these facilities that opened in certain of these years. In my State, this could have a tremendous impact on one hospital that opened in late 2000.

I cannot determine anywhere in the law or in regulation why these hospitals are suddenly being denied these payments. My staff has contacted CMS numerous times. No one has provided an acceptable written or verbal explanation of this seemingly arbitrary policy change.

I can tell you, I have one hospital that is affected by the amount of $2 million a year. A new hospital. They were following all the law, the regulations. Now, all of a sudden, they are called by CMS and told that they are no longer going to make the payments. Again, you may not have had a chance to look at this.

Secretary THOMPSON. I have not. I did not know anything about it, Senator Conrad. But I can assure you that, now that you have raised it, I will have my staff get in contact with your staff and we will try and work it through.

Senator CONRAD. All right. I appreciate that very much. I appreciate a productive working relationship. We consider you a neighbor, and we are glad to have you there.

Secretary THOMPSON. Thank you.

The CHAIRMAN. Thank you to all of my colleagues. Thank you, Secretary Thompson. I presume that you ought to expect a lot of questions in writing from people who were not here, because we only had one round of questions. Thank you very much.

Secretary THOMPSON. Thank you. Thank you, Senator Grassley and Senator Baucus. Thank you, Senator Breaux. Thank you, Senator Conrad.

The CHAIRMAN. The hearing is adjourned.

[Whereupon, at 11:11 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. JAMES M. JEFFORDS

Mr. Secretary, I'm going to add my voice to that of my colleagues and welcome you to the Committee. It has been a pleasure to work with you over the past few years and I particularly would like to commend you for the work you have done at the Department. Your tenure has been particularly challenging most especially with the ever-present threat of bioterrorism and you have handled it well.

However, I wish I could be as laudatory about, and welcoming to the budget proposal your presenting today—but I cannot. Frankly, I think the president's proposal is misguided because it continues to sacrifice and under fund key programs. I know you are here today to discuss the health financing components of the budget but just briefly I want to raise my concern that this budget proposal fails to keep up with many of the advancements we have made in a range of discretionary programs, including the Maternal and Child Health Block grant program which is under the jurisdiction of this Committee.

That the MCH block grant request is a flat lined, a zero-dollar increase over last year's funding is emblematic of the problem facing your critical health care programs. These flat lined requests don't mean that the programs will operate just like last year. Flat lining means; given the effects of inflation, fewer services will be provided. Where there are requested increases for programs, they are, with few exceptions, paltry. In rationalizing this budget one could say that it is the result of the looming budget deficits; but those are deficits of our own making and this prolonged under funding of vital government functions cannot stand.

You know that in the area of health financing issues I long ago added my support to creating a prescription drug benefit in Medicare as well as strengthening the reimbursement provisions for rural providers. With your help we were able to do that last year and again, I want to thank you for that effort. However, I also share the concerns raised by Senator Baucus that the Congress was not as fully informed as it should have been about the assumptions being made the expert actuaries in your Department. I urge you to ensure that information is available in the future.

I am not among those who were shocked by their estimate that the new Medicare drug benefit would cost more. I suspect the real number lies somewhere between the CBO estimate of $400 billion and the HHS estimate of $530 billion. But whatever the amount, whatever the cost, it represents a commitment to a program, to a goal, and to individuals and we should not think of reneging on our promise.

Finally, I'd once again like to state for the record that the new Medicare law isn't perfect and I know of several provisions that could be improved. I hope we can count on your help when the Congress decides to revisit those provisions and in the meantime, you will take the opportunity to share with this committee modifications that you believe would improve the law.

Thank you Mr. Secretary and Mr. Chairman.

PREPARED STATEMENT OF HON. TOMMY THOMPSON

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

This year's budget proposal builds upon HHS accomplishments in meeting several of the health and safety goals established at the beginning of the current Adminis-

tration. This year, Congress passed the comprehensive Medicare reform legislation, adding prescription drug coverage for seniors and modernizing the Medicare program.

- Since 2001, with the support Congress, the Administration has funded 614 new and expanded health centers that target low-income individuals, effectively increasing access to health care for an additional three (3) million people, a 29 percent increase.
- The Department established the Access to Recovery State Vouchers program, providing 50,000 individuals with needed treatment and recovery services.
- To support the President's faith-based initiative, HHS has created the Compassion Capital Fund for public/private partnerships to support charitable groups in expanding model social services programs. We awarded 81 new and continuing grants in 2003.
- HHS initiated a new Mentoring Children of Prisoners program to provide one-to-one mentoring for over 30,000 children with an incarcerated parent in FY 2004. The Department also created education and training vouchers for foster care youth, providing $5,000 vouchers to 17,400 eligible youth.
- In August 2001, the President and I invited States to participate in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. States use HIFA demonstrations to expand health care coverage. As of January 2004, HIFA demonstrations had expanded coverage to 175,000 people, and another 646,000 were approved for enrollment.

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

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

Your committee, Mr. Chairman, has jurisdiction over much of this budget. I am grateful for the hard work and achievements we have made together. Allow me to draw your attention to several key factors of the HHS budget so that we may continue to work together to address the needs of our Nation.

MEDICARE AND MEDICAID REFORM/MODERNIZATION

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

DRUG DISCOUNT CARD

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

ify for a $600 per year subsidy to purchase drugs. Medicare also will cover the enrollment fees for low-income seniors.

VOLUNTARY PRESCRIPTION DRUG BENEFIT

Responding to President Bush's pledge to add meaningful drug coverage to Medicare, MMA establishes a new voluntary prescription drug benefit under a new Medicare Part D. Starting in 2006, Medicare beneficiaries who are entitled to Part A, or enrolled in Part B, can choose prescription drug coverage under the new Part D. Under Part D, beneficiaries can choose to enroll in stand-alone, prescription drug plans (PDPs) or Medicare Advantage prescription drug plans (MA–PDs), and will be able to choose between at least two plans to receive their benefit. The law contains important beneficiary protections. For example, while the plans are permitted to use formularies, they must include drugs within each therapeutic category and class of covered Part D drugs, allowing beneficiaries to have a choice of drugs. In instances in which a drug is not covered, beneficiaries can appeal to have the drug included in the formulary. To reduce the number of prescribing errors that occur each year, HHS will develop an electronic prescription program for Part D covered drugs.

MEDICARE ADVANTAGE

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

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

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

PROVIDERS AND RURAL HEALTH

Recognizing geographic disparities in Medicare payments, MMA provides much needed relief to rural providers by equalizing the standardized amounts paid to both urban and rural hospitals. Of course, I don't need to tell this Committee how important these rural health investments are, and I congratulate Chairman Grassley, Senator Baucus, Senator Conrad, and others for ensuring that the programs were included in the final bill. Along with standardizing the base payment amounts to both urban and rural hospitals, MMA reduces the labor share of the standardized payment amount. In addition, Mr. Chairman, MMA increases payments for Disproportionate Share Hospitals (DSH) and provides greater flexibility to Graduate Medical Education (GME) residencies. The new law also increases flexibility for hospitals seeking Sole Community Hospital (SCH) status and reduces the requirements for achieving Critical Access Hospital (CAH) status. Critical Access Hospital status will receive increased payments under MMA, as the payment rate will be increased to 101 percent of allowable costs.

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

PREVENTIVE BENEFITS

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

REGULATORY REFORM/CONTRACTING REFORM

MMA includes a number of administrative and operational reforms, as well. For example, regulatory reform provisions require the establishment of overpayment recovery plans in case of hardship; prohibit contractors from using extrapolation to determine overpayment amounts except under specific circumstances; describe the rights of providers when under audit by Medicare contractors; require the establishment of standard methodology to use when selecting a probe sample of claims for review; and prohibit a supplier or provider from paying a penalty resulting from adherence to guidelines. In addition, MMA allows physicians to reassign payment for Medicare services to entities with which the physicians have an independent contractor arrangement. Under the new law, final regulations are to be published within three years, and all measures of a regulation are to be published as a proposed rule before final publication.

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

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

MEDICARE AND MEDICAID ESTIMATES

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

When Congress considered this act, Mr. Chairman, CBO estimated the cost of the bill at $395 billion from 2004 to 2013. The HHS actuaries have recently estimated the cost of the law as $534 billion from 2004 to 2013. Last week, the CBO Director told the House and Senate Budget Committees that CBO has not changed its estimate and that they continue to believe that the cost of the bill is $395 billion. Because the Medicare legislation makes far-reaching changes to a complex entitlement program with many new private-sector elements, there is even larger uncertainty in these estimates than usual.

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

ADDITIONAL MMA CHANGES

MMA addresses other issues facing the Medicare program including the program's long-term, financial security. To contain costs in the Medicare program, the law requires the Medicare Trustees, beginning in the 2005 annual report, to assess whether Medicare's "excess general revenue funding" exceeds 45 percent. As defined in the law, excess general revenue funding is equal to Medicare's total outlays minus dedi-

cated revenues. The Medicare Trustees shall issue a "warning" if general revenues are projected to exceed 45 percent of Medicare spending in a year within the next seven years. If the Trustees issue such a warning in two consecutive years, the law provides special legislative conditions for the consideration of proposed legislation submitted by the President to address the excess general revenue funding.

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

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

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

On August 15, 2003, President Bush signed Public Law 108–74. The law restores $1.2 billion in FY 1998 and FY 1999 SCHIP funds, and makes them available to states until September 30, 2004. The law also extends $2.2 billion in FYs 2000 and 2001 SCHIP funds, and revises the rule for the redistribution of the unspent funds from these allotments. For FYs 2000 and 2001 allotments, the law allows states that do not spend their entire allotment within the three-year period to keep half of those respective year's unspent amounts. The other half would be redistributed to states that have spent their entire amount of the respective year's allotments. The law also extends the availability of funds from the FY 2000 allotments through September 30, 2004, and the availability of FY 2001 allotment through September 30, 2005. The law gives some relief to states that expanded their Medicaid programs to cover additional low-income children prior to the enactment of SCHIP.

NEW FREEDOM INITIATIVE

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

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

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

The Administration looks forward to working with Congress to pass legislation authorizing me, as Secretary, to administer demonstrations to assist caregivers and children with serious emotional disturbances. Two demonstrations will provide respite services to caregivers of adults with disabilities and to children with severe disabilities. A third demonstration will offer home and community-based services for children currently residing in psychiatric facilities. The fourth demonstration will

address shortages of community, direct-care workers by providing grants to States to identify best practices and develop models. Direct-care workers play an important role in providing care to individuals living with disabilities in the community and this demonstration should help address these workforce challenges.

MEDICAID AND SCHIP MODERNIZATION

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

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

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

OTHER MEDICAID LEGISLATION

Extension of the Qualified Individual (QI) Program

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

Extension of Transitional Medical Assistance

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

Partnership for Long-Term Care

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

Refugee Exemption Extension

Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date, are not eligible for SSI

until they have obtained citizenship. Refugees and asylees are currently exempted from this ban on SSI for the first seven years they reside in the United States. To ensure refugees and asylees have ample time to complete the citizenship process, the President's budget proposes extending the current seven-year exemption to eight years.

Special Enrollment Period in the Group Market for Medicaid/SCHIP Eligible

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

MARRIAGE AND HEALTHY FAMILY DEVELOPMENT

This year, Mr. Chairman, the President is proposing a new marriage and healthy family development initiative. This Initiative is supported by funding increases in this Department's FY 2005 budget, encompasses a variety of new and existing programs, and impacts both mandatory and discretionary programs.

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

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

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

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

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

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

CHILD WELFARE

The Administration is proposing a nearly $5 billion budget for Foster Care. These funds will be used to support the President's child welfare program option, which provides states more flexibility in both the population served and allowable activities. The funds will be used to provide payments for maintenance and administrative costs for more than 230,000 children in foster care each month, as well as payments for training and child welfare data systems. The HHS budget request reflects savings associated with a legislative proposal to clarify the definition of "home of removal" in the foster care program in response to a court decision. The President's FY 2005 budget also requests $140 million for the Independent Living Program and $60 million for the Independent Living Education and Training Vouchers program. Additionally, to support the Administration's commitment to helping families in crisis and to protecting children from abuse and neglect, the President's FY 2005 Budget requests $505 million, full funding, of the Promoting Safe and Stable Families program.

CHILD SUPPORT ENFORCEMENT

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

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

COMPASSION AND FAITH BASED AGENDA

COMPASSION CAPITAL FUND

The FY 05 budget requests $100 million for the Compassion Capital Fund, which creates public/private partnerships that support charitable organizations in expanding or emulating model social service programs.

SAMARITAN INITIATIVE

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

DOMESTIC AND GLOBAL HEALTH IMPROVEMENTS

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

The President's budget proposal for FY 2005 also strives to meet the needs of our vulnerable populations. To protect our children from preventable illness, the budget proposes improvements to the Vaccines for Children (VFC) program to increase access to needed vaccines for underinsured children. In an effort to ensure we have enough vaccines when they are needed, the HHS budget request calls for a six-month stockpile of all regularly recommended vaccines for children, as well as for a stockpile of influenza vaccine for next winter. In addition to our Nation's children, we must not forget those struggling yet who are ready to help themselves out of the cycle of addiction and dependency. For FY 2005, the President proposes to double the Access to Recovery State Voucher program, for a total of $200 million, to provide vouchers to approximately 100,000 individuals seeking substance abuse treatment services.

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

MANAGEMENT IMPROVEMENTS

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

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

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