A REVIEW OF THE ADMINISTRATION'S FY2005 HEALTH CARE PRIORITIES

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BEFORE THE

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WEDNESDAY, MARCH 10, 2004

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The committee met, pursuant to notice, at 2:15 p.m., in room 2123, Rayburn House Office Building, Hon. Joe Barton (chairman) presiding.

Members present: Representatives Barton, Hall, Bilirakis, Upton, Gillmor, Greenwood, Cox, Deal, Burr, Whitfield, Norwood, Cubin, Shimkus, Shadegg, Pickering, Buyer, Bass, Pitts, Bono, Walden, Terry, Ferguson, Otter, Sullivan, Dingell, Waxman, Towns, Pallone, Brown, Rush, Stupak, Engel, Wynn, Green, McCarthy, DeGette, Capps, Allen, Solis, and Gonzalez.

Staff present: Patrick Morrisey, deputy staff director; Nandan Kenkeremath, majority counsel; Chuck Clapton, majority counsel; Patrick Ronan, majority counsel; Cheryl Jaeger, majority professional staff; Jeremy Allen, health policy coordinator; Eugenia Edwards, legislative clerk; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; and John Ford, minority counsel.

Chairman BARTON. Today we are going to have a hearing on the priorities of the Bush Administration's health care policies. Before we do our opening statements, I want to make a personal announcement for Chairman Tauzin. He informed myself and other members of the committee by telephone yesterday that he has been diagnosed with stomach cancer. He is undergoing a series of tests, is going to take a leave from the Congress for at least a month, will be operated no in the very near future, expects a full recovery, expects to be back in the House late spring.

He asked that I make this announcement, and I ask everyone to pray for himself and his family and help get them through this. But he is very optimistic. His doctors are very optimistic, and he expects a full recovery and to be back his usual active Cajun self this summer.

So with that I would also like to make an announcement that we have the Secretary with us until 5 p.m. this afternoon. Every member is entitled to make an opening statement. The chairman, ranking member of the subcommittee and full committee each are allowed 5 minutes. All of the members are allowed 3 minutes.

Any member who wishes to defer his or her opening statement will be given an additional 3 minutes in the question period.

So with that, the Chair would recognize himself for a 5-minute opening statement.

I want to welcome you, Secretary Thompson to the full committee hearing on the administration's 2005 fiscal year health care priority budget. Health care is a cornerstone of this committee's jurisdiction and has been for decades.

We have advanced significant health care through the Energy and Commerce Committee that have improved the quality of life for millions of Americans. Whether it affected Medicare, Medicaid, private insurance, FDA drug efficacy, medical device approval, or basic health care research and public health programs, this committee has played a pivotal role in the creation or modification of our most important health care policies.

As the chairman of the committee, I hope to carry on the fine tradition of my predecessors who have made strong commitments to increasing consumer's access to health insurance, to creating an affordable health care system, and to improving our Nation's public health infrastructure. It is my intent, and I am going to make it my policy to pursue these goals on a bipartisan basis.

We have acted, Republicans and Democrats, on a bipartisan basis in the recent past and have passed numerous critical health care bills. The Public Health Security and Bioterrorism Preparedness and Response Act, the creation of the Homeland Security Department, accelerated approval of devices in the FDA, and Project Bioshield are just a few of the bipartisan bills that this committee has pass into law.

On a not quite so bipartisan basis, we have also acted recently to enact comprehensive Medicare legislation that will provide our Nation's seniors with better access to prescription drugs and real relief from the high cost of some of those products.

I am looking forward, Mr. Secretary, today to hear you testify about how you plan to implement this new law that will benefit seniors and the specific ways you think it will reduce prescription drug prices.

There are many innovative, cost containment measures in the bill that is now law, and those really have not received too much attention, and so I hope that you will inform this committee of some of those issues.

The new Medicare law does many good things for our seniors. It has got a new prescription drug count discount card so that some seniors can receive an immediate reduction on their drug prices. You told me that 105 groups had applied to provide that card, and I am sure you will elaborate on that in your testimony.

We provide very generous low income subsidies for Medicare beneficiaries who need the most help, and the new bill will begin to modernize some of the most antiquated parts of the Medicare program.

Last year's passage of the Medicare law was not universally popular with this committee, but beginning today, I hope that friends on both sides of the aisle, Republicans and Democrats, who had some concerns about the bill, and I will put myself in that camps—I had some concerns about the bill, too—can focus on ways to insure that the law, now that it is the law, is fairly implemented in the way that will help Medicare beneficiaries the most.

Now is not the time to play politics and to try to reopen old wounds. I hope that we can work together to implement this on a bipartisan basis.

Finally, as you know, we are about to go through a new budget process. I would like to note to my consternation, quite frankly, many health care programs under this committee's jurisdiction are currently being funded without being authorized.

I have been told anecdotally, and I am trying to tie this down at the staff level, that 80 percent of the health care programs under the committee's jurisdiction are currently not authorized. I do not think that this is a responsible practice, Mr. Secretary, and I hope that you will work with the committee to begin the reprioritization process to determine how best use our precious Federal health care dollars.

It would be my goal over time to reauthorize or authorize all of the programs under the committee's jurisdiction. Programs that do not have an authorization at some point in time should not receive the same level of funding as they have in the past. Some may see this as controversial, but I believe it should be an important long-term goal of our committee.

I do not mind having a disagreement on how a program should be authorized, but I think that if we are going to spend Federal dollars, all programs that are spending Federal dollars should be authorized.

I want to work with you, Mr. Secretary, and the President and all the other members of the Cabinet and members of this committee to make progress on the important health care matters before us. We appreciate the fact that you are here today, and we appreciate the good work that you have done in the past, and we look forward to working with you in the future. We have a lot of work to do.

I will now recognize Mr. Dingell an opening statement.

Mr. DINGELL. Mr. Chairman, I thank you for this courtesy.

Mr. Secretary, welcome. I want to begin by expressing my high personal regard for you and to say to the committee that you are distinguished and able and a dedicated public servant, and we are delighted to have you before us.

I am here to speak today to the concerns and the feelings of the members on this side of the aisle. I confess myself severely disappointed by the President's proposed budget on health care. Rather than making advances to protect the health and welfare of Americans young and old, the budget, in fact, undermines key programs in the area.

Referring first to the issue of Medicare, the President's budget is noteworthy not for what is included, but rather what is not included. The budget includes no money to fix the gaping holes in the flawed Medicare prescription drug benefit bill passed last year. Seniors continue to face the doughnut hole that keeps getting larger. Drug prices keep skyrocketing, loss of existing quality retiree coverage, steep cuts to physician services over the next 10 years, and erosion of a program, Medicare, that has served them so well for better than 40 years.

Medicare will soon no longer be the program for millions of seniors to depend upon. It has changed and in many was not for the

better. Yet there is not one dollar in the budget to address these shortcomings, nor does the President's budget include needed funding to shore up Medicaid.

This is a program that provides health coverage for 51 million Americans, and the Children's Health Insurance Program, CHIP. The $20 billion in State fiscal relief is set to expire at the end of June, while the States are still struggling to overcome record budget deficits caused by the downturn in the economy.

And each of my colleagues here in the committee knows what this means to their own State. There is nothing in the budget to replace this.

Another $1.1 billion in funding for CHIP is set to expire in September, but there is no money in the budget for that either. According to the Kaiser Commission on Medicaid and the uninsured, the number of uninsured has increased by more than $3.7 million under this administration. Yet not only does this administration's budget include no money to improve the situation. It fails even to hold the line on the coverage that people have today.

Worse yet, the budget slashes the Medicaid program by $23.5 billion. This is done under the guise of eliminating unspecified fraud and abuse. It is quite possible that there is fraud and abuse in this situation, but it is equally probable that this will not be found, and so we will have to find a large amount of money to make this project whole or else to confront the problem of having States without the means to provide the necessary health care for deserving and needy Americans.

States are already in a $21 billion hole as a result of the President's budget under funding Medicaid and CHIP, but the President proposes slashing another $23 billion. This will leave a shortfall of better than $43 billion to State insurance programs in the coming decade.

The President's budget is similarly problematic with respect to public health programs. In the word of president for the Coalition of Health Funding, and I now quote, "By flat funding, cutting, or under funding with less than significant increases, the overall public health system is being strained to the breaking point. It is akin to death by 1,000 cuts, a slow dismantling of programs stretched beyond their limit by increasing demands. The budget misses important opportunities that public health agencies and programs provide to address the twin peril of increasing numbers of uninsured and unsustainable rising health care costs."

The budget also contains gimmicks such as interagency transfer. For example, the entire budget of the Agency for Health Care Quality and Research is funded from money transferred from the National Institutes of Health. This is the time that the National Institutes of Health are supposed to be receiving significant increases in funding to meeting plans announced earlier by the administration, and the demoralized and wasteful outsourcing programs are continued.

I hope, Mr. Secretary, that you will consider these hurtful cuts and remember that these are safety net programs upon which Americans depend.

We should also be working together to shore up programs to protect children, pregnant women, those with disabilities, the elderly,

and working families from seeing their health insurance coverage and other benefits eroded. But this administration's determination to enact tax cuts at any price prevents bipartisan work desperately needed to protect the health of Americans and the well-being of our citizens. I greatly regret this is the case.

I thank you, Mr. Chairman.

Chairman BARTON. Thank you, and I would note that both myself and Mr. Dingell were right on the 5-minute mark. So that is a good standard to start the opening statements.

Does the distinguished subcommittee chairman, Mr. Bilirakis wish to make an opening statement?

Mr. BILIRAKIS. Mr. Chairman, I am going to focus my questioning on the reimportation issue and would prefer that the Secretary have the excess time for that. So, therefore, I would defer and ask unanimous consent that my written statement be made part of the record.

Chairman BARTON. Without objection.

[The prepared statement of Hon. Michael Bilirakis follows:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you, Mr. Chairman. I am pleased that today we will be hearing from Health and Human Services Secretary Tommy Thompson. Secretary Thompson has appeared before this Committee a number of times in the past, and we welcome him back today and look forward to his testimony and his views on the Administration's fiscal year 2005 budget request for the Department of Health and Human Services.

Mr. Secretary, you have a formidable task ahead of you. While your budget request contains a number of new policy proposals, I think we both agree that your biggest job will be to oversee the implementation of the Medicare Modernization Act. As you are well aware, this new law represents the largest expansion of Medicare since the program was first created in 1965, and I look forward to working with you and your department to implement this landmark legislation.

I am particularly interested in hearing your perspective on the implementation of the Medicare prescription drug discount card and transitional assistance program. These new discount cards will be the first tangible benefits Medicare beneficiaries will enjoy as a result of the Medicare Modernization Act, and I know we share a mutual goal of ensuring that this program is as successful as possible.

I was also pleased to see that the Administration's request includes an increase of $219 million for the community health centers program, which as your budget request notes will result in services for an additional 1.6 million individuals in 330 new and expanded sites. As Congress continues to grapple with the best way to deal with the problem of the uninsured, I'm glad that we can come together behind this critical component of our healthcare safety net.

I'm interested in hearing more about the Administration's bioterrorism preparedness initiatives. While we have been fortunate in that our nation has not fallen victim to a major bioterrorist attack, the recent discovery of ricin in the Senate office building complex has highlighted our need to remain vigilant in our efforts to guard against biological and chemical weapons attacks.

Mr. Secretary, your department's budget request contains a number of other new initiatives, covering the spectrum from limiting the use of Medicaid intergovernmental transfers to encouraging healthy family development. I'm sure that today's hearing will highlight the fact that some of these initiatives are not without controversy. That's why I'm glad you were able to join us today to shed some further light on your fiscal year 2005 budget request and the thinking behind it. Thank you Mr. Chairman, and I yield back the balance of my time.

Chairman BARTON. Does the distinguished ranking member of the subcommittee, Mr. Brown, wish to make an opening statement?

Mr. BROWN. Yes, I do. Thank you.

Chairman BARTON. The gentleman is recognized for 5 or is it 3 minutes.

Mr. BROWN. Three. You had said 5 a minute ago.

Chairman BARTON. I thought so.

Mr. BROWN. Okay. I will do 3, and I thank you.

Thank you, Mr. Secretary, for joining us.

The President's health care budget is representative of his budget as a whole. It simply does not make sense as a response to the concerns of everyday Americans. The budget only makes sense if the President prioritizes tax cuts tilted toward the wealthiest Americans ahead of health care access and every other concern weighing on American families.

Whether you look at the funding set-aside for health care access, medical research, public health priorities, this budget treats health care like the redheaded stepchild. Last year, in his State of the Union address, the President told us that one of his major goals was high quality, affordable health care for all American. Keep that in mind when you look at how this administration treats Medicaid, the Nation's largest health insurer.

Medicaid covers 46 million Americans, and even through Medicaid is the only reason the uninsured rate didn't explode during the economic downturn, even though Medicaid covers 70 percent of nursing home care in this country, even though the States desperately need help keeping Medicaid afloat, the President's budget actually cuts Medicaid funding by $24 billion every 10 years.

Look in the context in a State like mine. One out of six manufacturing jobs has disappeared in the last 3 years; 300,000 unemployed. This Congress will not extend unemployment benefits to the 800,000 Americans who have seen their benefits expire in the last 3 months.

How exactly does stripping away health care coverage for millions of Americans contribute to the goal of assuring high quality, affordable health care for all Americans?

The President's State of the Union said our goal is to insure that Americans can choose and afford private health coverage that best fits their individual needs. I did not notice any funding in the President's budget to assure access to private coverage for 44 million uninsured Americans, much less the 46 million who rely on Medicaid. There are associated health plans. There are health savings account proposals in the Bush budget, but neither of these is actually paid for, and both of them undercut the broad pooling of risk that is essential to stable insurance markets.

No matter what mechanism the administration uses to drain dollars from Medicaid, starving the Medicaid program will hurt the same people: 20 million children, 13 million low income adults, 8 million disabled Americans, 5 million seniors who rely on Medicaid today, and frankly, every other American because Medicaid serves as a safety net when people lose their jobs and health care in times of economic hardship.

I have several questions about the President's priorities. For instance, I question why the President cited a laundry list of things the Nation must do, but did not once mention the need to control spiraling prescription drug costs. Strategies to rein in drug costs are conspicuously absent from the budget. They were, if you recall, prohibited strategies to rein in costs, prohibited in the actual Medicare bill that passed.

I question why the Bush Administration spend millions of taxpayer dollars on educational Medicare ads that don't actually educate, especially when you consider the Medicare drug benefit is not available for2 more years.

But the most important question is how can the President turn his back on the 46 million Medicare beneficiaries who are enrolled in that program.

I thank the chairman.

Chairman BARTON. We thank the gentleman.

Does the gentleman from Michigan, Mr. Upton, wish to make an opening statement?

Mr. UPTON. I am going to defer and take the 3 minutes.

Chairman BARTON. Does the gentleman from California, Mr. Waxman, wish to make an opening statement?

Mr. WAXMAN. I'm going to defer on an opening statement. I just want to welcome the Secretary, and I will use additional time for questions.

Chairman BARTON. The gentleman from Pennsylvania, he wishes to defer?

Mr. GREENWOOD. I defer.

Chairman BARTON. Okay. The gentleman from New Jersey, Mr. Pallone.

Mr. PALLONE. I have an opening, Mr. Chairman.

Chairman BARTON. The gentleman is recognized for 3 minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

President Bush's 2005 budget is proof that health care is not a priority of this administration. Furthermore, the administration has taken up the task of single handedly dismantling nearly every safety net health care program in the United States, while shoring up exorbitant amounts of money for corporate interest. Unfortunately, without dramatic changes made by Congress during the budget and appropriations process, more Americans, children, adults and the elderly will be uninsured and under insured due to the President's proposal to overhaul the Medicaid program, to overpay HMOs enormous amounts of money under the guise of providing a prescription drug program, and to provide a health tax shelter for primarily wealthy Americans.

During these difficult economic times, the President's budget is particularly cruel to the uninsured, poor and disabled, children and adults alike that rely on Medicaid and SCHIP to help with health care costs. By block granting a large portion of the Medicaid program, the Bush Administration simply passes the buck onto hard pressed States by shifting fiscal responsibility to States. The Bush proposal encourages States to limit their liability by capping enrollment, cutting benefits, and increasing cost sharing for millions of low income people.

Mr. Chairman, the amount of money that the President is planning on committing to Medicaid reform is grossly inadequate in providing health care to our Nation's most vulnerable populations.

In addition, any short-term relief that States receipt up front under the block grant will have to be paid by at the end of the 10-year budget window, and this is simply unacceptable. This proposal would not only harm Medicaid and SCHIP recipients, but also ag-

gravate fiscal problems plaguing most States, including my own State of New Jersey, which would be forced to pick up the slack.

We need to strengthen, not undermine the Medicaid and SCHIP programs by providing another direct infusion of money to States this year in order to insure health insurance for millions of low income Americans.

I am also deeply disappointed with the outcome of the Medicare bill that the President signed into law. It is painstakingly clear in the President's budget that his priority is to provide a rich benefit to HMOs, not seniors.

During debate on the bill, it was evident that HMOs were to be paid billions of dollars in order to entice private plans to enter the market to compete with Medicare. But the budget now reflects $46 billion in overpayments to HMOs, about $30 billion more than previously estimated.

And last, $70 billion in the budget for tax credits that will cover less than 5 percent of the uninsured population is a total waste. Those dollars can certainly be better spent on expanding programs that work, like expanding SCHIP to cover the parents of children in the program, strengthening Medicaid and implementing an elderly Medicare buy-in program.

Mr. Chairman, the number of uninsured Americans is a record 44 million. Fifteen out of every 100 Americans do not have health coverage, and the numbers are on the rise, and I think that that should be addressed, not the kind of money that we are spending here that is primarily helping wealth people and not doing enough to help the poor and the uninsured.

Thank you, Mr. Chairman.

Chairman BARTON. We thank the gentleman from New Jersey.

Does the gentleman from Georgia wish to make an opening statement?

Mr. DEAL. No.

Chairman BARTON. Does the gentleman from Michigan, Mr. Stupak, wish to make an opening statement?

Mr. STUPAK. Yes, Mr. Chairman.

Chairman BARTON. The gentleman is recognized for 3 minutes.

Mr. STUPAK. Thanks for holding this hearing, and, Secretary Thompson, thanks for being here today.

I ask that my full statement be made part of the record.

Chairman BARTON. Without objection.

Mr. STUPAK. Mr. Chairman, the President's budget cuts Medicaid by $10 billion over 5 years, and yesterday the Senate Budget Committee just passed their bill with a $11 billion cut in Medicaid over 5 years.

An $11 billion cut to Michigan means it would be losing approximately $385 million, or $77 million per year, in critically needed Federal funding. How does a State whose Medicaid enrollment has increased 30 percent in the last 4 years fill a $385 million hole?

But I look forward to hearing from the Secretary today about Michigan's multi-State prescription drug purchasing pool proposal. As the Secretary knows, Michigan has joined with Vermont to put forward an innovative approach to help save the States and the Federal Government money. They have proposed a multi-State pre-

scription drug purchasing pool that Michigan estimates will save them $40 million a year.

Other States like the approach and want to join, including Nevada, Alaska, Minnesota, and New Hampshire.

In the year since Michigan and Vermont made their proposal, CMS has put up one bureaucratic barrier after another. Michigan and Vermont repeatedly modified the plan in negotiations with CMS, but then in February CMS said it was going to deny the program.

Michigan's proposal makes sense to me. It combines the State's purchasing power, complies with CMS guidance on supplemental rebates, will save the States, Federal Government, and taxpayers money, and is based on a free market bidding using a commercial model. So I ask: what is the problem?

In a July 1, 2003, national public radio interview, former CMS Director Tom Scully said, "States have every right to negotiate and use their market power to get the best possible prices they can." He continued by saying, "The drug companies, I mean, obviously they are worried about their margins. They're worried about the States getting too organized and too powerful." So my question today will be to the Secretary: why is the administration blocking the Medicare Vermont-Michigan prescription drug pooling program?

And so I would look forward to your answering that question later.

Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Chairman BARTON. Thank you, Mr. Stupak.

Does the gentleman from Kentucky wish to make an opening statement?

Mr. WHITFIELD. Defer.

Chairman BARTON. Okay. The gentleman from Texas, Mr. Green, wish to make an opening statement?

Mr. GREEN. Thank you, Mr. Chairman.

And like my colleagues, Mr. Secretary, I want to welcome you back before our committee. I appreciate your coming over the last few years and to also appear before it to defend the budget, the administration's budget, and I hope it is a good defense.

We all know that the red ink is flowing in Washington, and we need to tighten our belt to get through the economic downturn, but I remind the members of this committee that our economic predicament is the result of the flawed policies of this administration.

When they arrived in Washington 3 short years ago, the administration inherited a strong economy and a $5.6 trillion 10-year surplus. It was squandered and turned into a projected deficit of $2.9 trillion. Now they blame the War on Terrorism or the bad economy, but in reality the administration's irresponsible tax cuts have caused this situation, and now they are trying to solve it by starving programs that are already under funded.

For example, the Community Access Program, which received $105 million in fiscal year 2004, was cut in the President's budget to $10 million for 2005. The CAP Program helps agencies improve access for all levels of care for uninsured and under insured, grants to communities across our country.

And I know in my own hometown of Houston the CAP grants have been critical in helping us secure more funding for community health centers and setting up of a hot line to improve access to health information and insuring the materials that are appropriate for Houston's averse culture.

If this budget is adopted, 193 CAP grantees are going to be out of luck and be the uninsured individuals, and their communities will suffer. But that is not the only program.

The Medicaid Program, possibly the most critical component of our health care safety net, suffers from cuts totaling $23.5 billion. And while I support efforts to curb waste, fraud, and abuse, I have a feeling these cuts will do much more damage to the program.

I also am concerned that the program does not help States that are already grappling with their escalating Medicaid and CHIPs costs. Last year my home State of Texas was forced to cut CHIP due to budget downturns. Since the CHIP enrollment has dropped from 507,000 to 399,000. That is 106,000 children in the last 6 months that have been dropped from CHIP in Texas alone, and more are adding every day.

Dental, vision, Hospice benefits are being eliminated. Children must wait 90 days for CHIP coverage to begin, and copays and premiums have increased, and coverage has been reduced from 12 months to 6 months. And our Nation's low income children cannot afford anymore sacrifices.

Mr. Chairman, I appreciate the time, and again, Mr. Secretary, welcome and I look forward to your testimony.

Chairman BARTON. I thank you, and I think, Congressman Green, you might want to make an introduction. Your county judge just walked into the room at the back of the room if you would like to introduce him.

Mr. GREEN. Well, I would. My County Judge Robert Eackles, we served in the legislature, and he is here not to talk about CHIP, but to talk about transportation funding.

CHIP is a problem in Harris County. Thank you, Mr. Chairman.

Chairman BARTON. Always glad to have one of our county judges from Texas before the committee.

Does Mr. Norwood wish to make an opening statement?

Mr. NORWOOD. Mr. Chairman, after a couple of the statements, I am almost inclined, but out of respect for the Secretary, I will ask that mine just be submitted for the record.

Chairman BARTON. Without objection.

Does the gentlelady from Missouri wish to make an opening statement?

Ms. MCCARTHY. No, Mr. Chairman. I am just so glad the Secretary is here and look forward to his testimony.

Chairman BARTON. Does the gentlelady from Wyoming wish to make an opening statement?

Ms. CUBIN. Mr. Chairman, I will defer mine.

Chairman BARTON. Okay. Does the gentlelady from California wish to make an opening statement?

Ms. CAPPS. Just to say welcome.

Chairman BARTON. Okay. Does the gentleman from Illinois wish to make a statement?

Mr. SHIMKUS. Waive.

Chairman BARTON. Okay. Does the gentleman from Texas, Mr. Gonzalez, wish to make an opening statement?

Mr. GONZALEZ. Waive.

Chairman BARTON. Okay. The gentleman from Arizona?

Mr. SHADEGG. Mr. Chairman, I have less self-discipline than some of my colleagues, and so I am not going to waive my opening statement.

I simply cannot sit by——

Chairman BARTON. The gentleman is recognized.

Mr. SHADEGG. Thank you.

Mr. Secretary, thank you for being here. Thank you for all you are doing for health care.

Mr. Chairman, thank you for holding this hearing.

I simply cannot sit here and watch the political comments that have been made so far in opening statements and sit silent. It is not in my nature.

I think, quite frankly, on the issue of prescription drugs you can debate the merits of that bill. You and I did, in fact, debate them the night that it passed. I think, quite frankly, one point is true; this administration saw a need, and after years and years and years of nothing happening, this administration passed a bill.

Now, as you know, I have some problems with that bill, but it is now the law of the land, and its critics want to just drag it down. I think instead we ought to be talking about improving it. And I think American seniors ought to at least acknowledge that we have tried to do something.

I know that prescription drugs are a critical part of health care for everyone in America. Indeed, you cannot have health care if you do not have access to the prescription drugs which are the marvel of today's modern medicine. I myself am on several.

And it seems to me that after failing for year after year after year after year, those who did not help us pass it just want to carp at it. I think it is important to say thank you to you and your administration for getting a piece of legislation passed.

I would like to see it improved. As you know, I think PPOs should play a larger part in that particular piece of legislation. I particularly think non-risk PPOs should be playing a larger part in that legislation. But at least we have something on the table, and so I compliment you for that.

I also want to compliment you for the President's acknowledgement of the importance of tax credits for the uninsured. There have been comments made here today that we are not spending enough. We are not doing enough. We are not spending enough for the uninsured.

But the President said in his State of the Union, if he could get this Congress to act, he would support tax credits for the uninsured, and they are the way to address this problem.

I keep telling my Republican colleagues that right now we are providing health care to all Americans under EMTALA. You walk into an emergency room in America today and you get health care, but you get it in the most expensive and, I would argue, least efficient venue when you walk into an emergency room and you ask to have a cold treated.

And yet we have already made the decision as a nation that no one in this country should go without a basic level of health care. We can continue to deliver that health care through emergency rooms the way this Congress is doing under EMTALA and waste billions of dollars in resources, or we can step up to the plate as the President has called for us to do and pass tax credits to deal with the problems of the uninsured. Give every American who is uninsured a tax credit and tell them that they have got to use that tax credit to go out and buy health insurance.

And it can be an affirmative tax credit that we actually pay to them, and it can be an advancable tax credit so that they get the money in advance and they apply it to their insurance company, and they get health care coverage so that they quit showing up at emergency rooms, and they could go to a doctor or a clinic where they deserve to get health care.

And so I applaud the President for trying to lead in that direction. The alternative of continuing to having them come to an emergency room is simply unacceptable.

I hear the discussion of SCHIP. I will tell you the history of SCHIP. SCHIP is one more government program where it is difficult to get people to sign up. If we give tax credits, people would be anxious to come and sign up, and they would be sold those policies, and we would get coverage, and we would deal with the problems.

Chairman BARTON. The gentleman's time has expired.

Mr. SHADEGG. So I applaud the gentleman, and I urge you to continue in the direction you are going.

Chairman BARTON. We thank the gentleman.

Does the gentlelady from California, Ms. Solis, wish to make an opening statement?

Ms. SOLIS. Yes. Thank you, Mr. Chairman.

Chairman BARTON. The gentlelady is recognized for 3 minutes.

Ms. SOLIS. Thank you, and good afternoon.

I would also like to submit my statement for the record, but just make a few comments, if possible.

Chairman BARTON. Without objection, so ordered.

Ms. SOLIS. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. It is good to see you here.

I also have some concerns that have been previously expressed by some of the members here, especially with respect to the Medicaid budget cuts that are being proposed in the President's budget.

While our economy and our State in California are suffering dramatically, I wonder why the administration would choose to punish a health care program that is designed to particularly help low income and disabled people.

And I know that the administration's proposal to seek to limit the use of intergovernmental transfers, IGTs, within the Medicaid Program would have a dramatic effect in California. We have been using it efficiently. I know the purpose there is to cut down on fraud and abuse, but I think California, which is the sixth largest health care provider in the States who has a large proportion of uninsured, could truly benefit from a continuance in flexibility and use of this particular program.

I also want to mention that I hope that you will talk today about racial and ethnic health disparities. The landmark 2002 Institute of Medicine report titled "Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care" really opened America's eyes to health disparities facing communities of color in our country.

Whether it is the fact that Latinos face diabetes rates twice that of whites or Asian Americans who have the highest tuberculosis rates in the country, disparities in health care are one of the most critical issues in health care today. It is simply unfair that Americans face different health care outcomes and diseases simply because of the color of their skin or their ethnic background.

I encourage the administration to take more active steps in curbing health care disparities.

And one last thing I would like to say is that I hope the administration could take a better look to insure that regulations that are currently pending would actually increase access for limited English proficient individuals and require that federally funded health care providers meet the nondiscrimination requirements of Title VI in the Civil Rights Act.

I know that is something that you have talked about in the past. I would really like to see more substantive enforcement of those measures on the books.

And then just last, I would say that in the State of California, we are very concerned about not only accessing health care for uninsured, but making available career paths for low income in under represented communities, and in that vein, I would ask that we really do as much as we can to provide up front funding so that Latino health care professionals will, indeed, be able to enter into the field and become those first responders and providers in our community.

Cutbacks in those programs are very vital. I had a recent conference that we held, the Hispanic Task Force on Health, in New York where 200 health care professionals came. That was one of the most outstanding priorities for the conference, to talk about how we could increase health care professions in minority communities.

So with that, I would just submit my statement and hope that you can answer some of our questions.

Thank you.

Chairman BARTON. We thank the gentlelady.

Does the gentleman from Indiana wish to make an opening statement?

Mr. BUYER. I defer.

Chairman BARTON. Okay. Does the gentleman from Maryland, Mr. Wynn, wish to make an opening statement?

Mr. WYNN. Thank you, Mr. Chairman.

Let me begin by saying welcome, Mr. Secretary. We are delighted to have you with us.

I want to open by saying thank you for your support of the consolidation of the Food and Drug Administration facility at White Oak in my district. It is a great facility, and I think when completed it will do a wonderful job for our Federal employees who will work there and also a great service to the country.

I want to mention a couple of items that I am concerned about and hope that you will also consider. The first has to do with the issue of health care. I recognize the administration is attempting to move in this direction with its tax credit proposal.

I believe the proposal is too limited. It would only cover about a quarter of the 43 million people who are uninsured.

I worked with my Republican colleague, Ms. Kay Grange of Texas, on a bipartisan bill that uses the tax credit approach, but has a much more generous benefit package that would cover at least half of the uninsured, and also provide catastrophic coverage beyond that which the administration has considered.

So I would say to you that the first step of the administration is just too limited, and I hope you will consider an option to provide a much more generous benefit to help more people to make it a really successful program.

Second, on the issue of malpractice, there seems to be a great deal of apathy for tort reform as a solution to medical malpractice premiums. The fact of the matter is even where you have had caps in States, they have not resulted in a decline in malpractice premiums.

And so I think this approach ought to be reconsidered, and the so-called panacea of tort reform as the answer to malpractice should be rejected. It has not, as shown in California where only some form of price control was able to bring down the medical malpractice rates.

I have worked on this issue in this committee and suggested what we need to do is study insurance company investment practices because there seems to be a correlation between that and rising malpractice insurance rates. I think that is an approach that the administration ought to consider or at least look at rather than just focus on tort reform.

And finally, on the issue of drug reimportation, I think Congress has spoken very loudly, as well as many State governments that they believe that reimportation is a viable approach. Your agency has basically said that you do not think that this ought to be done or can be done safely, and I think that that ought to be reconsidered.

I think it can be done safely even if you take a Canada only approach. There is clearly a demand to bring down the cost of drugs. It does not do any good to have a program, such as was passed this past year, if the price of drugs keeps going up.

Even if you give a discount card, even if you have Federal assistance, if the price of the drugs are not brought down, we will not address that problem.

And, finally, I think you need the jurisdiction to negotiate drug prices to bring prices down and to benefit seniors. Obviously, the administration and my Republican colleagues see that issue differently, but I have to say in candor that that is something that I think you ought to be in a position to do.

Chairman BARTON. The gentleman's time has expired, unfortunately.

Mr. WYNN. And with that I will relinquish the balance of my nonexisting time.

Thank you, Mr. Chairman.

Chairman BARTON. Thank you.

The gentlelady from California, Ms. Bono.

Ms. BONO. Thank you, Mr. Chairman. I will pass.

Chairman BARTON. Okay. The gentlelady from Colorado, Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

I will submit my full opening statement for the record.

Let me just take an opportunity to greet the Secretary and talk about an issue that we both care a lot about, which is stem cell research.

As we all know, stem cell research is just one of many promising scientific discoveries made in the last decade. There is a lot of belief in the scientific community that stem cells have the potential to cure many diseases, like diabetes, Parkinson's, nerve damage, and that is just a few, and we are really on the brink of exciting discoveries in stem cell research.

But despite this important research, President Bush's 2001 Executive Order has greatly inhibited its potential. When the President declared a moratorium on Federal support for stem cell creation in August 2001, the President restricted the research to only existing and, as it turned out, minimal numbers of stem cell lines.

The policy has not only had the effect of making people wonder about what this research is supposed to be. It has also had a chilling effect on scientists applying for any NIH money to conduct the research.

After 2 years, what we have found out is instead of the promised 78 embryonic stem cell lines, today we only have 15, and there is general agreement that these lines which have aged and may be contaminated with mouse feeder cells maybe unsuitable for therapeutic use in humans. Instead of the promised $100 million in funding for the NIH stem cell research, only $17 million was allocated in 2003.

These unfulfilled promises have forced universities and private entities to step in. I know the Secretary is aware, as I am, last week Harvard University announced that it had created 17 new stem cell lines which now more than doubles the world's supply. Harvard is offering these new lines to researchers for free, but no Federal research can use these lines because of the President's policies.

This means that researchers who are committed to finding cures cannot use these lines, and because of the limited supply nd quality of the NIH stem cell supply, their research is severely constrained.

In the meantime, scientists around the world are making advances, and the U.S. is literally relegated to the sidelines.

Well, some people say science should be allowed to proceed with this research unchecked, and it is great that private entities are developing the lines. I disagree though. The actions of some scientists may be unethical. There may be corporate greed if this research continues without Federal oversight and Federal support.

And so, Mr. Secretary, I guess I would ask you to continue to join in the fight to expand stem cell research and not to limit it because Americans are dying every day, and we can cure diseases for millions of people in this country and around the world.

Thank you, Mr. Chairman.

Chairman BARTON. I thank the gentlelady.

Does the gentleman from Oregon wish to make an opening statement?

Mr. WALDEN. Yes, Mr. Chairman, I would.

Chairman BARTON. The gentleman is recognized.

Mr. WALDEN. My colleague from California and I were just discussing the fact that by the time we get down to us for the round of questions, the answerer may have to leave. So I decided to go ahead and pose my questions now so that perhaps they can be addressed in the future, Mr. Chairman.

Three things really, Mr. Secretary. One is thank you for your leadership not only on Medicare and implementing the new law, but also in banning ephedra. it is an issue I raised after the tragic death of Steve Beckler, the Baltimore Orioles pitcher in our oversight investigation subcommittee, and I was pleased to see the FDA take on that issue.

I do have an issue though about some of the ephedra free supplements that have now flooded the market and are advertised to accomplish basically the same things, and I hope that your department will watch those closely and take a good look, especially some of those as well as herbal supplements and anabolic steroid precursor supplements which ingested sometimes metabolize in the body into anabolic steroids. So that is certainly an issue we are concerned about.

Also, Mr. Secretary, the issue of Medicare rural health flexibility programs which we have briefly discussed, FLEX, is so important in our rural communities. I recognize that the Medicare Modernization Act will provide more than $20 billion in payment adjustments to rural providers.

However, these adjustments address the longstanding inequities in the Medicare payment system and serve to bring rural providers closer to a level playing field with their urban counterparts. So I have some concerns about the funding levels in FLEX and the reasons behind that reduction.

And finally, Mr. Secretary, if you could give us some sense of what portion of the $1.8 billion budget recommendation for health centers will be dedicated to new start applicants versus funding expansions of current sites, and the reason that is especially important to me not only as a co-chair of the Rural Health Care Caucus, but also representing what is about the seven of the largest congressional district in America, I have one clinic in specific that serves an area where there are .8 persons per square mile, and so it is a very remote, rural area, no doctors, no hospitals, a clinic that is struggling to survive. These funds would obviously be important, and they are looking at applying for them.

So those are my three questions, Mr. Chairman, at this point, and I yield back the balance of my time, and I thank the Secretary for his leadership on a multitude of these issues.

Chairman BARTON. We thank the gentleman from Oregon.

Does the gentleman from Maine wish to make an opening statement?

Mr. ALLEN. I do not.

Chairman BARTON. Okay. Does the gentleman from Nebraska wish to make an opening statement?

Mr. TERRY. No, I do not.

Chairman BARTON. The gentleman from Oklahoma wish to make an opening statement?

Mr. SULLIVAN. Waive.

Chairman BARTON. Seeing no other members present, all members not here shall have the requisite number of days to have their opening statements in the record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. BARBARA CUBIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Thank you, Mr. Chairman. I know everyone is eager to hear from our witness today, so in the interest of time, I will get right to the point of my statement.

My primary concern in the budget is its overall effect on rural states. For those of you who may be unfamiliar with my home state of Wyoming, we are very much a frontier state.

According to the Webster's dictionary, "frontier" is defined as a region that forms the margin of settled or developed territory; a new field for developmental activity. In health care terms, frontier refers to an area with 6 people or less per square mile.

As a region with roughly 100,000 square miles, and 500,000 people, with rugged mountainous terrain, and an unforgiving climate, Wyoming is perhaps this country's last frontier.

So when vital health programs are reduced or cut from the budget, patients in my district scramble for care, and many health care professionals pack up their desk and head home for good.

That is not an exaggeration.

I am very pleased with the President's budget increases for the National Health Service Corps and Community Health Centers because Wyoming relies a good deal on these programs. I applaud the Administration for its continued support in these areas.

I am however concerned about the cuts to a variety of other rural health programs that directly benefit my state.

Examples include: State Offices of Rural Health, the Health Professions Program, and Rural Health Outreach and Network Development Grant—to name a few.

While I understand budgetary constraints, we simply cannot cut the legs out from under rural health communities across this country. The effects could be devastating.

The Medicare bill did provide more than $20 billion in payment adjustments for rural providers. Again, I applaud the Administration for its support of that. However, those adjustments in the Medicare bill addressed the long-standing inequities in the Medicare payment system.

Those provisions serve to bring rural providers closer to a level playing field with their urban counterparts.

However, we cannot assume the provisions in the Medicare bill eliminate the need for grant programs that specifically address the health needs of rural communities.

I look forward to having the Secretary address these rural programs and, with that, I yield back the remainder of my time.

Thank you.

PREPARED STATEMENT OF HON. VITO J. FOSSELLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Thank you, Secretary Thompson, for appearing before the House Energy and Commerce Committee to present the priorities of Department of Health and Human Services. I appreciate your continuing work on implementation of the Medicare Prescription Drug, Improvement, and Modernization Act and look forward to working with you to ensure a smooth transition to a more efficient and effective Medicare program and new prescription drug benefit to ensure Medicare beneficiaries have access to affordable healthcare.

Your assistance to Congress during the formation of this law was invaluable, particularly your coordination of all relevant agencies with Congress to establish a meaningful and workable pancreatic islet cell demonstration program. As you know, Diabetes affects approximately 17 million individuals in the U.S. today, and the prevalence is rapidly increasing. I share your dedication to fighting this disease through education, prevention, treatment, and research toward a cure.

A primary factor in the rising occurrence of Diabetes is unhealthy lifestyle habits and choices. Sixty-four percent of Americans are overweight or obese, leading to increased health risks including Type II Diabetes, heart disease, stroke, cancer, osteoarthritis, and premature death. According to a CDC study released on March 9, 2004, poor diet and inactivity will soon become the leading cause of preventable death in the United States. Already, there are an estimated 400,000 deaths per year caused by poor diets and inactivity. In addition to causing premature death, obesity drastically reduces the quality of living for obese individuals and costs our nation over $117 billion per year in medical expenses alone.

Because obesity and the deadly and debilitating health risks associated with it are largely preventable, there is great hope for solutions to these challenges. That hope rests with individuals whose responsibility it is to change the trend. We in Washington must provide the necessary tools for Americans to modify their habits and become healthier and more fit. HHS' efforts to educate the public on nutrition, exercise, and the health consequences of obesity is the right approach. In the short time since these initiatives have been established, we have seen promising results. In the past two years, the Department of Health and Human Services has implemented several innovative education and prevention programs to urge Americans to improve their nutrition and physical activity habits, including *Steps to a HealthierUS* and the *Healthy Lifestyles and Disease Prevention* initiative. I am pleased to see those programs are working. Last month, the CDC reported a 34 percent increase in physical activity among American youth attributable to the VERB multicultural youth media campaign. I encourage you to continue this work.

In my District, Brooklyn and Staten Island have the second and third highest rates of obesity in New York City. These communities are responding with the help of healthcare providers, businesses, and not-for-profit organizations by establishing local programs to educate the community and prevent obesity. I look forward to working with you to coordinate these local efforts with HHS' healthy-living initiatives.

PREPARED STATEMENT OF HON. MARY BONO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Secretary, I would like to take this opportunity to thank you for allowing us time to speak with you today regarding our nation's health care. I commend the efforts undertaken by your administration during this critical juncture in health care. I look forward to hearing your answers to what will inevitably prove to be a wide array of questions.

Seniors, which comprise nearly 20% of my district, are finally confronted with more choices and more savings, as the Medicare Bill becomes implemented. I am most proud that our work in both Congress and the Administration has now guaranteed providing all senior citizens prescription drug coverage under Medicare a reality.

While I am looking forward to speaking with you later today regarding your department's positions on AIDS funding, the Women's Initiative, and the need for healthier living, I do want to express my concerns regarding the stability of the Medicaid program. As I am sure you are aware, the MediCal program in my state is in financial despair. One of my greatest fears is that safety net hospitals will not receive the funding guaranteed them by the Medicare bill due to Medicaid cuts in this year's budget. As you know, I feel that it's of critical importance to ensure the continued funding for safety net hospitals across the country. These facilities, which include public hospitals, children's hospitals and private safety net hospitals, are integral to the access to care for low-income individuals. With no budget allocation for IGTs, California's DSH hospitals are in jeopardy. I intend to work with my colleagues on the Energy and Commerce to find a workable solution.

Mr. Secretary, I want to once again thank you for the work you and your staff put in to focusing on real progress in improving health care not only for seniors, but for all Americans. Thank you for your time in allowing me to share my thoughts today.

PREPARED STATEMENT OF HON. JOHN SULLIVAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Thank you Chairman. I would like to thank Secretary Thompson for appearing before the Committee today to discuss the Administration's health care funding priorities this year. As a member of the Speaker's Prescription Drug Task Force, I am well aware of the Medicare prescription drug plan and I look forward to working

with your Department to bring the benefits of this landmark plan to the American people as soon as possible.

I would also like to mention a very important issue to my state, and that is the uninsured. Oklahoma ranks fourth in the nation for the number of uninsured. Over 150,000 Oklahomans are employed by the health care industry in a variety of fields and I believe that *your* Department and *this* Committee are well-placed to help change that situation not just in Oklahoma, but across the nation.

Thank you and I look forward to the testimony today.

PREPARED STATEMENT OF HON. EDWARD J. MARKEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Thank you Mr. Chairman.

Secretary Thompson, when you testified before the Committee a year ago, I asked for your support for my efforts to exempt homebound beneficiaries—with permanent and severe disabilities—like late-stage Alzheimer's, Parkinson's and ALS—from restrictions on their departures from the home. Patients with these debilitating conditions are not trying to exploit or cheat the home health program rather, they and their loved ones depend on it to provide a measure of comfort in the face of extremely difficult circumstances. Last year, I succeeded in attaching an amendment to the Medicare bill to create a two-year demonstration project that exempts this vulnerable Medicare population from restrictions on their departures from the home. The demonstration will begin by June of this year. I greatly appreciate your support for this initiative and look forward to continuing to work with you and the CMS staff to ensure the success of this demonstration and secure ultimate repeal of the outdated homebound restrictions.

I encourage CMS to continue to build on the work it has begun designing the demonstration project. CMS staff members have been working closely with my staff and Committee staff, and I am confident that this good work will continue while the confirmation process moves forward.

In addition to helping the homebound, there are a number of other important health care priorities that I look forward to discussing with you at today's hearing.

A generation has passed, 39 years since President Lyndon Johnson signed the Medicare bill into law. On that day, President Johnson told the American people: "No longer will this nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this country."

While the Medicare program has done much to improve the health of our nation's seniors, today they face new injustices in seeking access to affordable health care. Current policy tells the elderly that they cannot buy prescription drugs from Canada where such drugs are accessible and affordable. It allows the pharmaceutical companies to place an embargos on vital medication so they can protect their profit. It bans the Federal Government from using its massive purchasing power to negotiate lower of prescription drug prices for our senior citizens, the disabled and others who are most in need of affordable prescription drugs.

Because of our healthcare policies hard working low- and middle income families either uninsured or underinsured are put in a position were their financial stability is undermined by any medical expense. The Bush Administration's budget would allow the Children's Health Insurance Program funds to expire, a $1.1 billion cut that shows that some in the Administration still do not recognize that it is cheaper to maintain childhood health than to pay for chronic care resulting from childhood disease.

Another area of great concern to me is inadequate funding for medical research. Over the last 5 years the NIH funding has doubled. This has allowed great advances to be realized, including treatments for such ruinous conditions such as Alzheimer's disease. However a 2.6% increase in NIH funding for 2005 will not allow us build on the tremendous advances now being made. Just a few days ago, the Congressional Alzheimer's Task Force heard from researchers and families about the damage that will be done to ongoing research if we fail to continue to provide a higher level of funding.

American citizens also must be concerned about who has access to their private health and concurrent private financial information.

Doctor/patient confidentiality today is no longer what it used to be. In the world of integrated health systems anywhere from 80-100 employees may legitimately have access to a patient's medical records.

If patients perceive that they no longer can trust in medical confidentiality, patients are likely to withhold vital information or avoid seeking health care services all together. When we OFFSHORE our medical information to countries that do not

recognize the sanctity of private information, how can we have faith that our private information will remain confidential. The Department of justice has recently stated, federal law "does not recognize a physician-patient privilege." DOJ has said that patients "no longer possess a reasonable expectation that their histories will remain completely confidential." I would like to know if the Secretary agrees with such statements. If so, aren't we risking destruction of the fundamental trust that patients relay on for peace of mind? Will we not undermine the quality of medical care by destroying the doctor patient communication that has existed before Hippocrates?

I look forward to hearing the testimony of the Secretary this afternoon, and I yield back the balance of my time.

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you Mr. Chairman for holding this hearing, and thank you Secretary Thompson for coming to talk with us today.

Mr. Secretary, while there is much to be concerned about in this budget, I'm very pleased that it included an increase of $26 million to ensure medical devices are safe, effective and available to Americans as quickly as possible.

I encourage you to remain steadfast in ensuring public health and safety is not jeopardized. I look forward to working with you to ensure that patients continue to have *safe* access to the lifesaving treatments they need, and deserve.

Having said that, I'm very discouraged with this year's budget proposal and its health care program. I'm especially disheartened to see that the President wants to block grant Medicaid.

The President is once again advancing an agenda that includes capped allotments for state Medicaid programs.

Mr. Secretary, I support giving states more flexibility to use the funds we provide them with. However, caps on Medicaid spending will reduce the flexibility of the program, not increase it. It's this flexibility that permits states to respond to economic recessions and uninsurance.

Specifically, Mr. Secretary, I'm most troubled with the President's proposal to put limits on the intergovernmental transfers (IGTs). IGTs are legitimate funding mechanisms for the states—approved by both Democrats and Republicans. To change this program overnight at a time when states are in a fiscal crisis, when there is a rising number of Medicaid beneficiaries and uninsured, is reckless.

IGTs are the funding mechanism for the Disproportionate Share Hospital (DSH) Program in my state of California. These DSH funds are essential for California's safety net hospitals to be able to provide health care services.

Restriction of the IGTs would have a *severe* impact on the state of California.

There has got to be a better way and I'm committed to working with you and my colleagues on both sides of the aisle to develop it. I hope you're willing to work with us.

I'm also deeply concerned about the President's funding for the NIH. I was so disappointed to see that the President has increased the NIH budget by a mere 2.7 percent.

Not only do discoveries supported by the NIH help patients, but the funding that NIH provides for research is so often the catalyst for future innovation that stimulates our economy and increases investment in burgeoning industries such as biotechnology.

I'm also concerned about the President's limits on federal financing for embryonic stem cell research. Scientists will soon need a wider variety of cell lines for research and clinical applications—I hope the Administration is supportive. We cannot and must not restrict advances in the promising future of human biology.

Lastly, Santa Cruz County, California is experiencing a severe drain of physicians to neighboring counties due to disparity in physician payment rates. Several other large California counties are affected by the same conditions.

Congress delegated the responsibility to CMS to manage physician payment localities. I've encouraged CMS to work to ensure that practice costs are properly linked to Santa Cruz County reimbursements. I met with then CMS Administrator Scully in July 2003 but CMS has failed to address this issue since then. We need a resolution to this now.

I intend to follow-up on this issue during my question time.

Thank you and I look forward to your testimony Secretary Thompson.

PREPARED STATEMENT OF HON. ELIOT ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, thank you for having this hearing today, and thank you Mr. Secretary for taking the time to come before us today to discuss the President's budget.

In looking over the President's budget I was disappointed to see that there is little in the way of bolstering health care for the uninsured, aside from a modest increase for community health centers. Further, the budget highlights priorities aimed at reducing a state's ability to care for the uninsured, such as further restrictions on the use of intergovernmental transfers. The budget calls for almost $10 billion in savings over 5 years by "curbing" the use of intergovernmental transfers.

Mr. Chairman, I and other Members of this Committee fought hard to reach an agreement a few years ago that allowed some intergovernmental transfers to remain in place if the money was used for health care purposes. New York has always used money generated from intergovernmental transfers to plug holes in the very fragile health care safety net in the state. At a time of soaring unemployment, fiscal crisis in states, and record numbers of uninsured Americans, I think it is highly irresponsible to cut $2 billion per year in vital health care funding that states have come to rely upon. Mr. Secretary, I would like to hear some details of this proposal and hope to work with you to ensure that New York, and other states, are not adversely affected by the additional restrictions in the President's budget. When I hear that President Bush is trying to save money by cutting health care funding, it boggles my mind because in the end we will either pay now or we will pay a much heavier price later. In this case, with a floundering economy and those without jobs and insurance on the rise, we will pay a very heavy price by saving money on the backs of those most in need.

Mr. Chairman, in my limited time I could not begin to talk about all the problems within the President's budget proposal but I believe that the move to cut $10 billion in Medicaid funding exemplifies what this budget stands for: an attack on the poor and uninsured and a lack of vision in regards to what our countries needs are. The budget does not adequately address problems with Medicare, Medicaid, hospital payments, disaster preparedness, AIDS program funding, NIH and health research funding and many, many more important health initiatives that are simply struggling to survive due to lack of funding. Mr. Chairman, I hope that my colleagues on this Committee recognize that the initiatives in this budget need vast improvement and I look forward to working with you to achieve that goal.

Thank you for your time Mr. Secretary and I yield back.

PREPARED STATEMENT OF HON. KAREN MCCARTHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Thank you Chairman Barton and Ranking Member Dingell for convening this hearing to discuss the HHS budget and our nation's health care priorities. I also want to thank Secretary Thompson for taking the time to discuss national health concerns with the committee.

Health care remains a critically important priority in my district in Kansas City and across the nation. Last September, the nonpartisan Kaiser Family Foundation released a survey which revealed that employer based health care premiums soared 13.9 percent in 2003, the largest single year increase since 1990 and the third straight year that insurance premiums have increased by double digit percentages. According to a recent US Census report, Almost 11 percent of Missouri's citizens were without any form of health insurance in 2002. That represents a full percentage point increase since 2001, equivalent to roughly 56,000 individuals without care in my state. Often the last resort for the uninsured, Kansas City clinics and community health centers which offer assistance to the uninsured have seen their resources stretched to the limit. As record numbers of Americans struggle to afford health care, national leadership is needed to address health care access and affordability issues.

Secretary Thompson, you and I continue to be steadfast supporters of efforts to maintain fitness and to ensure that Americans have access to exercise as preventive care. Americans spend billions each year on prescription drugs to fight diabetes and cholesterol. Encouraging good health habits and preventive measures can easily yield greater benefits for a fraction of the cost. I want to commend your efforts to encourage healthier lifestyles and for your recently announced public education campaign encouraging Americans to take steps to improve their overall physical fitness.

I am lead sponsor of H Con Res 34, bipartisan legislation to recognize the efforts of employers and insurers who are taking steps to promote healthy lifestyles

through exercise, thus reducing health care costs. I appreciate your support of that effort and look forward to working with our new Committee Chairman to advance this cost effective legislation through our committee and the House this year.

I also look forward to hearing the Secretary's explanation of the Administration's decision to cut funding from both the CDC's bioterrorism training account and the Health Resources and Services Administration. Both of these programs help fund bioterrorism prevention efforts in my district and across the nation. I recently visited two impressive Truman Medical Center (TMC) facilities. Last year, TMC received $18,000 to help purchase equipment and train staff to handle a bioterrorist incident. The proposed cuts could endanger this important source of funding and put citizens in my district at risk. I hope you will address this important issue.

PREPARED STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Good morning. I am pleased that the committee is holding today's hearing and I welcome Secretary Thompson.

To begin, I would like to express my concerns with the Medicaid budget cuts contained in the President's budget. With the troubling economy and state budgets nearing the breaking point, I am surprised that the Administration would choose to punish a health care program designed to assist low-income and disabled people. These are our most vulnerable populations, and it is unfair to put their health care at risk by scaling back services. I know that the Administration's proposal seeks to limit the use of intergovernmental transfers (IGT) within the Medicaid program. However, the state of California has appropriately used IGTs to fund safety net hospitals, emergency room services, and other vital programs. It would be unfair to punish California, which has the sixth largest proportion of uninsured residents in the country.

Another issue facing California—and the entire country—is that of racial and ethnic health disparities. The landmark 2002 Institute of Medicine report Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare really opened America's eyes to the health disparities facing communities of color in this country. Whether it's the fact that Latinos face a diabetes rate twice that of whites, or that Asian Americans have the highest tuberculosis rates in the country, disparities in healthcare are one of the most critical issues in health care today. It is simply unfair that Americans face different health outcomes and diseases simply because of the color of their skin or their ethnic background. I encourage the Administration to take a more active role in curbing health disparities.

One important step the Administration could take right now concerning disparities would be to ensure that your pending regulations concerning access for limited English proficient individuals require federally-funded health care providers to meet the nondiscrimination requirements of Title VI of the Civil Rights Act. The Congressional Hispanic Caucus and Congressional Asian Pacific American Caucus have expressed our strong support for strengthening the proposed guidelines you issued last year to ensure that limited English proficient individuals enjoy the meaningful access to federally-funded health care services they are guaranteed under the law.

With respect to the shortage of health professionals in medically underserved communities, I was extremely disappointed to see that the Bush budget slashes funding for health professions training programs by 96%—from $294 million last year to just $11 million this year. As you know, these programs are a key source of doctors and nurses in medically underserved areas. The Congressional Hispanic Caucus recently held a forum in New York City to talk to Latino health professionals about the need to recruit more doctors and nurses into underserved areas. Time and again, these health professionals told us that federal programs that help with loan repayment and training costs are key to attracting more health care personnel into underserved areas.

Finally, I want to express my strong support for the work done by the Centers for Disease Control and Prevention's National Center for Environmental Health. The community I represent has many environmental problems that are impacting the community's health. Whether it's gravel pits impacting asthma rates or groundwater contamination forcing families to buy bottled water for fear of their health, environmental health is an issue that is key to the San Gabriel Valley and East Los Angeles area I represent. The prevention and research being done by the CDC is extremely important to the families I represent, and I encourage the Administration's strongest support for the agency.

Thank you, I look forward to the Secretary's testimony.

Chairman BARTON. Mr. Secretary, we welcome you to the committee, and we recognize you for such time as you may consume to elaborate on your formal statement.

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

Mr. THOMPSON. Thank you very much, Mr. Chairman. It is a pleasure for me to address you in that capacity.

Mr. Dingell, who is not here but is a friend, and Congressman Bilirakis and members on both sides whom I have gotten to know over the 3 years and truly respect and appreciate this opportunity.

Thank you, Mr. Chairman, for inviting me to discuss the President's fiscal year 2005 budget for the Department of Health and Human Services.

In my first 3 years at the department, we have made tremendous progress in improving the health, the safety, and the independence of the American people. We continue to advance in providing health care to seniors and to lower income Americans and improving the well-being of children and strengthening families and in protecting the homeland.

We have reenergized the fight against AIDS at home and abroad. We increased access to quality health care especially for minorities, the uninsured, and the under insured.

We are helping smokers free themselves of their debilitating habit through a national quit line which I requested the department to fund internally, and we now have done that and set it up.

And with your help, 3 months ago President 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 1.2 percent over fiscal year 2004, but an increase of 26 percent since 2001.

Before this committee, this includes a broad range of activities, such as Medicaid, Medicare, and the Public Health Service. Internally, we have improved the efficiency of the department and have improved programs' outcomes. We have consolidated information technology contracts for the eight major operating divisions down to one, and we have consolidated the HHS E-mail system.

HHS is the managing partner of grants, DOTGOV. It provides a single, unified, and streamlined interface for citizens to find and apply for Federal grants from all Federal agencies.

In order to strengthen our bioterrorism preparedness and public health system, we have requested $4.1 billion, up from $300 million in 2001.

Community health centers increase access to health care for the uninsured. We are proposing $1.8 billion for health centers to provide health care services to 15 million Americans. As you all know, I am a big proponent of information technology. That is why we provided a computer language called SNOMED to providers at no charge.

We are leading the way in developing standards for electronic medical records, and last month I announced and FDA ruled to

prevent medication errors by requiring bar codes on medicines and blood products.

Last September, my department announced 12 steps to a healthier U.S., grants totaling more than $13 million to support community initiatives to promote better health and prevent disease. These included 23 communities, including one tribal organization, 15 small cities and rural communities, and seven large cities.

The department will expand the program this year with an additional $44 million, and we have requested $125 million for these programs in 2005.

Through our new Freedom initiative, we are working to help the elderly and the disabled by promoting home and community based care.

We look forward to working with all of you, especially 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.

And I am pleased to announce this afternoon that we are awarding $21 million this year and another $32 million next year to State and local governments that counsel Medicare beneficiaries. These funds will help beneficiaries understand the new benefits that have been provided by the Medicare Modernization Act.

This year funding represents a 69 percent increase above the fiscal year 2003 total and reflects the increased need for one on one advice and counseling for Medicare beneficiaries which are provided by the staff and the volunteers and State health insurance assistance programs, or SHIPS.

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

[The prepared statement of Hon. Tommy G. Thompson follows:]

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

Good morning, Mr. Chairman and members of the Committee. I am pleased to present to you the President's 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 Administration. Last year, Congress passed the comprehensive Medicare reform legislation, adding prescription drug coverage for seniors and modernizing the Medicare program.

- Since 2001, with the support of 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 better 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 programs in the HHS budget total $67 billion in budget authority, a 1.2 percent increase. In addition, the budget identifies approximately $500 million in mandatory program savings.

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

Drug Discount Card

MMA establishes a new, exciting Medicare approved prescription drug discount card program, providing immediate relief to those beneficiaries who have been burdened by their drug costs. From June 2004 through 2005, all Medicare beneficiaries, except those with Medicaid drug coverage, will have the choice of enrolling in a Medicare-endorsed drug discount card program. With the discount card, beneficiaries will save an estimated 10 to 15 percent off the retail cost of their drugs. 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. Most with low incomes—below 135 percent of the Federal poverty level—will qualify for a $600 per year subsidy to purchase drugs unless they have health insurance that includes drug coverage. Medicare also will cover the enrollment fees for low-income seniors who are eligible for the $600 subsidy.

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. 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.

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

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

Providers and Rural Health

Recognizing geographic disparities in Medicare payments, MMA provides much needed relief to rural providers by equalizing the standardized amounts paid to both urban and rural hospitals. Along with standardizing the base payment amounts to both urban and rural hospitals, MMA reduces the labor share of the standardized payment amount. In addition, 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.

Other providers will also 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 screenings, 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, 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 of enactment.

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 a plan by April 1, 2004 and implement this plan by October 1, 2005 for shifting the appeals function from SSA to HHS. 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. The CBO Director has 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. The law requires the Medicare Trustees, beginning in the 2005 annual report, to assess whether Medicare's "excess general revenue Medicare funding" exceeds 45 percent. As defined in the law, excess general revenue Medicare funding is equal to Medicare's total outlays minus dedicated revenues. The Medicare Trustees shall issue a "warning" if excess general revenues Medicare funding is 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 warning.

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 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 $1.75 billion, 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 Congress to secure its passage this year. The Administration recognizes the success of consumer directed programs that give people the opportunity to manage their own long-term care, as delineated by the development of its Independence Plus Waivers. Thus, we propose allowing individuals who self-direct all of their community-based, long-term care services to accumulate savings and still retain eligibility for Medicaid and Supplemental Security Income. Under current law, beneficiaries are discouraged from accumulating savings because it could jeopardize their eligibility for Medicaid and SSI. Under the Living with Independence, Freedom, and Equality (LIFE) Accounts Program, individuals who self-direct all of their Medicaid, community-based, long term supports will be able to retain up to 50 percent of savings from their self-directed Medicaid community-based service budget at year end, contribute savings from employment, and accept limited contributions from others. Ultimately, LIFE Accounts would enable individuals to save money to reach long-term goals (for example, to purchase expensive equipment or attain higher education) and to obtain greater independence.

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

Medicaid and SCHIP Modernization

This Committee is well aware that Medicaid spending continues to rise each year. Total Federal and State Medicaid spending for 2004 is projected to be $301 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 restricting the use of certain types of intergovernmental transfers. The proposal would deem as "unallowable" certain Medicaid expenditures that result in Federal Medicaid 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. Individuals eligible for SSI automatically are eligible for Medicaid. 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 Eligibles

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.

ADMINISTRATION FOR CHILDREN AND FAMILIES

I would like to congratulate the House on passing the Temporary Assistance to Needy Families (TANF) reauthorization. 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

As the Committee may remember, President Bush announced in his State of the Union address an expanded 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.

EXPANDING ACCESS TO HEALTH CARE FOR AMERICANS

One of the most important issues on which we can continue to work together, is expanding access to quality health care for all Americans. In 2001, the President launched an initiative to expand access to health care by creating 1,200 new or expanded health care sites and serving an additional 6 million people by 2006. Since the initiative inception in 2002, the Health Centers program has significantly impacted more than 600 communities, serving over 13 million patients, 3 million more than in 2001, 40 percent of whom have no health insurance coverage, and many others for whom coverage is inadequate. States also use Health Insurance Flexibility and Accountability (HIFA) demonstrations to expand health care coverage. As of January 2004, HIFA demonstrations expanded coverage to 175,000 people and another 646,000 were approved for enrollment. While we have made significant strides in this endeavor, there is still much work to be done.

In FY 2005, the President's budget request will continue to expand resources for Health Centers to a level of $1.8 billion, an increase of $219 million over FY 2004. This increase will result in increased services for an additional 1.6 million people in approximately 330 new and expanded sites. At this level, almost 15 million uninsured and underserved individuals, nearly 7 million from rural areas, will have access to comprehensive preventative and primary care services at over 3,800 health sites across the country.

ACCESS TO RECOVERY

Mr. Chairman, the FY 2005 budget represents the fourth year of the President's strong commitment toward leading our nation's battle against addiction. Current use of illicit drugs among students has declined by 11 percent between 2001 and 2003. However, there continues to be an unmet need for drug treatment services. The FY 2005 budget will provide 100,000 individuals with drug and alcohol treatment benefits by doubling the funding to $200 million for the Access to Recovery State Voucher Program. This initiative will allow individuals seeking clinical treatment and recovery support services to exercise choice among qualified community provider organizations, including those that are faith-based. The program's emphasis is on objective results and is measured by outcomes, including decreased or no substance use, no involvement with the criminal justice system, attainment of employment or enrollment in school, family and living conditions, and social support.

DISEASE DETECTION AND BIOTERRORISM PREPAREDNESS

The FY 2005 request for HHS bioterrorism activities is $4.1 billion, an increase of $155 million above FY 2004, and $3.8 billion above the FY 2001 level. Funds will be redirected to carry out a new interagency bio-surveillance initiative to prepare against a potential bio-terrorist attack. The Centers for Disease Control and Prevention (CDC), in coordination with the Food and Drug Administration (FDA), the Department of Homeland Security, and the Department of Agriculture, will be working to improve the response to bioterrorism through early detection with the Bio-Surveillance Initiative. The goal of this program will be to develop new tools and procedures, which will allow us to identify potential disease outbreaks more rapidly.

We also continue our work in building the Strategic National Stockpile of drugs, vaccines and medical supplies that can be shipped anywhere in the country on short notice with a request for $400 million in FY 2005. The FY 2005 budget includes a three-year financing plan to expand our antibiotic stockpile to be able to provide post-exposure anthrax treatment from 13 million to 60 million people. In FY 2005, we have included a contingency provision that will allow us to transfer up to $70 million to the Stockpile from funds available for State and local preparedness should the added funds be needed.

Our nation's ability to detect and counter bioterrorism ultimately depends on the state of biomedical science, and the National Institutes of Health (NIH) will continue to ensure full coordination of research activities with other Federal agencies in this battle. The FY 2005 budget includes $1.74 billion for NIH biodefense research efforts, an increase of $120 million, or 7.4%. Included with this biodefense total is $150 million to support the construction of extramural BioSafety laboratories to help develop medical protection from pathogens that could be used in bioterrorist attacks, and to create highly sophisticated laboratories that can aid federal and state authorities in the event of a public health emergency, such as a bioterror attack, or the emergence or re-emergence of a dangerous and infectious disease like SARS. Prior to FY 2002, only a few laboratories in the United States were capable

of conducting research on potential bio-terrorism agents. The $150 million investment in FY 2005 will fund an additional 20 Biosafety Level 3 laboratories in locations throughout the country.

The ability to mitigate the health effects of radiation exposure in the event of the use of a limited nuclear or radiological device in a terrorist attack presents a critical challenge for which little progress has been made in the last forty years. For FY 2005, $47 million is requested in the budget for the Public Health and Social Services Emergency Fund, to be coordinated and managed by NIH. This new initiative will support targeted research activities needed to develop medical countermeasures to more rapidly and effectively treat nuclear or radiological injuries.

Influenza Vaccine

Throughout my time as Secretary, many steps have been taken to allow for improved access to vaccines for those in need and better methods to combat the spread of influenza viruses. The Medicare re-imbursement rate to physicians for the administration of the flu vaccine increased from $3.98 per dose in CY 2002, to $7.72 in CY 2003, an increase of +94 percent. In each of FY 2004 and FY2005, $40 million will be used for creating a stockpile of children's influenza vaccine to ensure this past year's shortages do not reoccur. While these previous measures have improved access to vaccines, we must also look toward future improvements. In an effort to further develop the capacity to respond swiftly to pandemic flu, the FY 2005 budget doubles our investment in pandemic flu preparedness to $100 million.

Childhood Vaccines

A significant goal toward improving the health of the nation is ensuring that at least 90 percent of all two-year olds receive the full series of vaccines to help meet their basic health needs. In an effort to improve immunization rates across the nation, the FY 2005 budget requests $1.9 billion for childhood immunization.

The Budget includes two legislative proposals in Vaccines for Children that I believe should be strongly supported by the members of this Committee. This legislation would enable any child who is entitled to receive vaccines under the Vaccines for Children (VFC) program to receive them at State and local public health clinics. There are hundreds of thousands of children who are entitled to VFC vaccines, but can receive them only at Community Health Centers and other Federally Qualified Health Centers. In the past, when these children went to a State or local public health clinic, they received vaccines financed through discretionary appropriations to the CDC. However, as modern technology and research has generated new and better vaccines, that cost has risen dramatically. For example, when the pneumococcal conjugate vaccine became available, it increased the cost of vaccines to fully-immunize a child by about 80 percent. The most recent information indicates that 19 States are limiting access to this important vaccine; this legislation would help solve this access problem.

Legislation is also needed to restore tetanus and diphtheria vaccines to the VFC program. The VFC authorization caps prices at such a low level that no manufacturer will bid on a VFC contract. As a result, the vaccines that are provided to VFC program children through the public health system have to be financed with scarce discretionary resources.

CDC will continue to build a six-month, vendor-managed stockpile of all routinely recommended childhood vaccines. Between FY 2004 and FY 2006, CDC plans to invest an additional $583 million to meet the target quantities needed for a six-month stockpile. Vaccines from the stockpile can be distributed in the event of a disease outbreak and will mitigate the effect of any potential manufacturing supply disruption.

COMPLETION OF THE DOUBLING OF NIH

Building on the momentum generated by the fulfillment of the President's commitment to complete the five-year doubling of the NIH budget, the FY 2005 request provides $28.8 billion for NIH. This is an increase of $764 million, or 2.7 percent, over the FY 2004 level. In FY 2005, over $24 billion of the funds requested for NIH will flow out to the extramural community, which supports work by more than 212,000 research personnel affiliated with 2,000 university, hospital, and other research facilities across our great nation. These funds will support a record total of nearly 40,000 research project grants in FY 2005, including an estimated 10,393 new and competing awards.

NIH remains the world's largest and most distinguished organization dedicated to maintaining and improving health through the use of medical science. Major advances in scientific knowledge, including the sequencing of the human genome, are opening dramatic new opportunities for biomedical research and providing the foun-

dation for un-imagined results in preventing, treating, and curing disease and disability. Investment in biomedical research by NIH has driven these advances in health care and the quality of life for all Americans, and the FY 2005 budget request seeks to capitalize on the resulting opportunities to improve the health of the nation. In an effort to target research gaps and opportunities that no single NIH institute could solve alone, The FY 2005 budget allocates $237 million for the Roadmap for Medical Research initiative, an increase of $109 million or 85 percent over FY 2004. This initiative is set up in three core themes of establishing new pathways to discovery, inventing the research teams of the future, and re-engineering the clinical research enterprise.

PREVENTION INITIATIVES

More than 1.7 million Americans die of chronic diseases—such as heart disease, cancer, and diabetes—each year, accounting for 79 percent of all U.S. deaths. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. The budget includes $915 million for Chronic Disease Prevention and Health Promotion, an increase of $62 million.

The FY 2005 budget includes $125 million, an increase of $81 million, for the Steps To A Healthier US Initiative. This increase will fund the State and community grant program initiated this past September to reduce the prevalence of diabetes, obesity, and asthma-related complications, targeting those at high risk. Last year these funds reached 23 communities including seven large cities, one Tribal consortium, and 15 smaller cities and rural areas, and more areas will benefit during the upcoming year. Also a total of $10 million will be used to expand the Diabetes Detection Initiative, which targets at-risk populations. The aim of this initiative is to reach these populations where they live, work, and play through a customized, tailored approach with the aim of identifying undiagnosed diabetes.

The FY 2005 budget request for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is $220 million, an increase of $10 million over FY 2004. NBCCEDP has helped to increase mammography use by women aged 50 and older by 18 percent since the program's inception in 1991. NBCCEDP targets low-income women with little or no health insurance and has helped to reduce disparities in screening for women from racial and ethnic minorities. With the requested increase, the NBCCEDP will provide an additional 32,000 diagnostic and screening services to women who are hard-to-reach and have never been screened for these cancers.

MENTAL HEALTH TREATMENT

In meeting the President's goal of transforming the mental health system and increasing access to mental health services for some of our most vulnerable citizens, the FY 2005 budget includes $913 million for mental health services, a increase of $51 million over FY 2004, or +6 percent. As an important step in reshaping this delivery system, the budget proposes $44 million for State Incentive Grants for Transformation. These new grants will support the development of comprehensive State mental health plans to reduce system fragmentation and increase the level of services available to people living with mental illness.

Recent studies have found that 20 percent of individuals experiencing chronic homelessness also have a serious mental illness. This request proposes $10—million for the Samaritan Initiative, an Administration-wide initiative to reduce chronic homelessness, jointly administered with the Departments of Housing and Urban Development and Veterans Affairs. Through this initiative, States and localities will develop processes to better enable access to the full range of services that chronically homeless people need, including housing, outreach, and support services such as mental health services, substance abuse treatment, and primary health care.

FIGHTING HIV/AIDS

HIV is one of the most serious and destructive challenges facing humanity in our world today. No country, whether large or small, rich or poor, can escape the devastation it brings. All have citizens whose lives have been destroyed by this horrible disease, and our commitment to ending this pandemic is both strong and unwavering. No nation in history has ever committed the time, energy, and fiscal resources that the United States has invested in this effort. The FY 2005 HHS total budget will continue this emphasis with the request for HIV/AIDS funding of $15 billion, a 31 percent increase over FY 2001 for both domestic and global HIV/AIDS prevention, care, treatment and research activities.

Specifically, the FY 2005 budget includes $784 million for States to purchase medications for persons living with HIV/AIDS. At this level, monthly AIDS Drug As-

sistance Programs will increase from 93,800 clients in FY 2004 to 100,000 clients in FY 2005. Also included is $53 million for the HIV/AIDS in Minority Communities activities funded under my office, which reflects the first time the budget proposes an increase, to support innovative approaches to HIV/AIDS prevention and treatment in minority communities.

FOOD AND DRUG ADMINISTRATION

The FY 2005 request for the Food and Drug Administration (FDA) is $1.8 billion. Within this total, there are program increases of $179 million, partially offset by $30 million in management and other savings. The FY 2005 budget requests significant increases to ensure the safety and protection of our food supply; and accelerate the availability of new, safe and effective drugs and medical technologies, including biodefense medical countermeasures.

FDA has already dramatically expanded its work to prevent intentionally contaminated foods from entering the U.S. The budget requests a $65 million major expansion for a total of $181 million dedicated to FDA's efforts to protect Americans from risks of deliberate food contamination. The FY 2005 budget takes the next step, making the investments needed to accelerate Federal and State ability to detect contamination. FDA will work with the USDA Food Safety Investigation Service to substantially expand the laboratory capacity of their State partners, and will work to find faster and better tests to detect contamination, including ones that could be used on-site at ports, processing plants, and other food facilities.

Over the past three years, FDA has bolstered the nation's food defense through increase in port security, food import inspections, and additional food security personnel. Specifically, the Agency hired more that 655 additional food security personnel, and as a result, achieved a fivefold increase in field import examinations between FY 2001 and FY 2003.

The Animal Drugs and Feeds program protects the health and safety of all food producing, companion, or other non-food animals; and, assures that food from animals is safe for human consumption. This program is responsible for ensuring the availability of safe effective veterinary drugs and has a role in the prevention of Bovine Spongiform Encephalopathy (BSE) or "Mad Cow Disease" from being transmitted through animal feeds. The FY 2005 budget requests $30 million, an $8 million increase, to expand efforts to prevent BSE or "Mad Cow Disease." FDA will intensify its efforts to keep forbidden animal proteins out of cattle feed.

The budget seeks a $26 million increase in budget authority for FDA's Medical Devices program to ensure medical technologies are safe, effective, and available to Americans as quickly as possible. The requested increase is consistent with the intent of the Medical Devices User Fee and Modernization Act (MDUFMA) and meets the agreement communicated in an October 29th letter from OMB to the Congressional leadership. The increase will support the necessary investments, including hiring 50 FTE, to accomplish review goals that become increasingly aggressive through FY 2007. In FY 2005, FDA expects to meet goals related to the review of applications for improvements to existing devices and certain new devices that manufacturers claim are as safe and effective as ones currently in the marketplace. FDA will review 75% of applications for each of these application types within 180 and 90 days respectively. This percentage of applications reviewed will become more challenging each year through FY 2007. For breakthrough technologies and other new, innovative devices, ambitious review goals take effect in FY 2006, and in FY 2007 when decisions will be made on 90 percent of applications within 320 days. FDA has committed to meeting these performance goals—the original goals agreed upon in MDUFMA, as stated in the October 29th letter. Also, the Administration is willing to request similar funding levels in FY 2006 and FY 2007 and ensure the user fee program continues beyond FY 2005 by working with Congress to modify MDUFMA to preclude the requirement that funding amounts below the FY 2003 and FY 2004 intended levels must be made up in FY 2005.

Our budget also includes $499 million, an increase of $23 million for the Human Drugs program, and $173 million, an increase of $4 million in Biologics. Of the total spending on these activities, $253 million will be from industry specific user fees. These funds will ensure the safety and efficacy of new and existing human drugs and biologics—helping to make medicines safer, more affordable, and more available.

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 man-

agers 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.

Chairman BARTON. Thank you, Mr. Secretary.

And the Chair would recognize himself for the first 5 minutes of questions.

The agency that you are responsible for has got a budget of all the programs under its jurisdiction of $580 billion. Four hundred and eighty-two billion of that is the Medicare-Medicaid Program. I have had my staff prepare a very preliminary list, and we show that there are 93 specific line item programs on your jurisdiction that are currently not authorized.

What, if anything, should this committee and your agency do about generically the programs that are not authorized, but yet funds are still being requested to be expended upon.

Mr. THOMPSON. I think we should do it in a systematic fashion, Mr. Chairman. I agree with you. I think they should be reauthorized. We have several programs right now that are currently in front of the Congress, the reauthorization of Head Start, the reauthorization of TANF and several other particular programs that have not been approved by this Congress.

But when you look at it, there are several programs in Health Resource and Service, HRSA, Centers for Disease Control and Prevention. Most of the programs at NIH have not been reauthorized, some of them going clear back to 1996. Substance abuse, SAMHSA are all programs that need to be reauthorized, and I would hope that we can work with you, find out which ones are the easiest in a systematic fashion being able to get them reauthorized through this committee and then hopefully through Congress.

Chairman BARTON. One of the programs that you just mentioned, the National Institutes of Health, we have doubled their budget over the last 5 years. We now have an appropriation of approximately $28 billion.

Mr. THOMPSON. That is correct.

Chairman BARTON. But of the 60 specific line item programs in the NIH's budget, only 16 are authorized. That means that 44 are unauthorized.

I am also told that you as Secretary have no direct control over any of the NIH budget initiatives. What should we do, and again, I am not asking for specific prescriptions, but what should we do about that program where we have doubled the budget and yet

most of the programs are not authorized, and there does not appear to be much accountability in the entire program.

Mr. THOMPSON. Well, I think that Congress has got definitely a responsibility on oversight, as I do as Secretary, and I think we need to work together to find ways in which we can improve that oversight, and find ways, Mr. Chairman, how we can get these programs reauthorized.

I think it would do a world of good for this committee and Congress to have myself and the Director, Elliot Zerhouni, come up with a program on how we could reauthorize these on a systematic basis.

I think it would be good for this committee to get a chance to look at what NIH is doing. I think you will be quite impressed, as I am. And I think if you had a chance to reauthorize them, it would give you better information, a better expertise, and as well as being able to put in some further oversight and some other kinds of controls that may be necessary.

Chairman BARTON. Well, I am not opposed to obviously the NIH, and I am not opposed to increasing their budget. I do not want to leave the wrong impression, but I do believe we should have accountability, and I do believe that we should take our role as oversight seriously on this committee, and NIH is certainly an area where we need to do that.

I have got about a minute left. Let me ask you a little bit different kind of a question. I was one of the members on this committee that pushed for a prescription drug benefit card. I had asked that it be the alternative to the insurance program that is in the Medicare reform bill, but while the basic insurance package is being put together, the prescription drug card is the short-term benefit for seniors that need prescription drugs.

That program is supposed to kick in, I believe, in June of this year for low income seniors. They will get a cash subsidy of $600 for all income seniors. I think for a cost of $30 they can get this card and should make available to them quite a number of prescription drug discounts.

Could you elaborate on that briefly and the timetable?

Mr. THOMPSON. Absolutely, Mr. Chairman. We had receive 105 application. Two of those have now either withdrawn or consolidated. We will be making a decision before March 23 of what applications are going to be improve. It is going to be able to issue the Medicare card.

And then in April, they are going to be able to publicize their information, get the information necessary, their drug discounts, and then in May they will be able to start enrolling individuals.

We will be putting up a transparent Web site as well as informational line 1-800-MEDICARE. You will be able to call with your prescriptions. We will be able to tell you exactly what this particular card will give you as a credit, a reduction in your drugs. You are a senior citizen. You put in the prescriptions that you have to take, and we can tell you where the closest pharmacy will be and also what the cost savings will be.

And since it is going to be increased and improved and updated every single week, it is going to have a tremendous tendency to drive down drug costs because everybody is going to be able to look

at it, every Member of Congress, every senior, every employer, and so it is going to be a very good deal.

And we are already working on the transparency of it, and I just announced in my opening statement that we were going to put in some additional money, almost 50 percent more for the SHIPS. So those are the individuals in the districts that are going to be able to go into the homes, as well as to senior centers, and be able to explain it.

Chairman BARTON. Do you expect to have it available by June of this year?

Mr. THOMPSON. We are going to have it by June 1.

Chairman BARTON. Okay.

Mr. THOMPSON. In fact, we are ahead of all of our projections.

Chairman BARTON. Very good. I will now recognize Mr. Dingell for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you.

Mr. Secretary, I begin by expressing my great affection and respect for you.

Mr. Secretary, I have a question here which you can answer, I believe, true or false. Mr. Secretary for the past 13 years Part B deductible has been $100. That amount will grow to $110 next year, and according to CBO estimates by $166 by 2013. Is that true or false?

Mr. THOMPSON. I would say that is true.

Mr. DINGELL. Now, is this statement true or false? Every Medicare beneficiary who elects Part B coverage during their initial enrollment period pays the same premium, but under the new law beginning in 2006, about 1.2 million Medicare beneficiaries who have higher incomes will pay higher premiums than others for the same benefits.

Mr. THOMPSON. That is income averaged, yes, and it will make over 8,000.

Mr. DINGELL. That is true.

Now, is this true or false? Medicare beneficiaries will have to join a private drug plan, HMO or PPO in order to receive prescription drug coverage, and that they cannot get coverage under a fee-for-service plan like they get it with hospital or other coverage at this time. Is that true or false?

Mr. THOMPSON. Well, it takes a little bit more than true and false. They still will have their current program.

Mr. DINGELL. They will have the current plan, but to get a drug——

Mr. THOMPSON. The current program, but the drugs will be by either a PPM or a PPO or an HMO.

Mr. DINGELL. So they have got to make that change and will not have that coverage.

Now, Mr. Secretary, beneficiaries living in six different areas designated as pilot projects will be forced to pay much higher premiums for their traditional fee-for-service carrier as a result of Medicare's experiments with a voucher program, sometimes called premium support or privatization.

Is that statement true or false?

Mr. THOMPSON. That starts in 2010, and that presupposes that Congress does not change it or that there have not been modification.

Mr. DINGELL. So it is true if Congress does not change that?

Mr. THOMPSON. If Congress does not.

Mr. DINGELL. They could charge whatever they want and give whatever level of——

Mr. THOMPSON. And it also depends upon how competitive it is going to be.

Mr. DINGELL. All right. Now, Mr. Secretary——

Mr. THOMPSON. It does not necessarily mean there will be higher rates.

Mr. DINGELL. Can you assure me that it will be the same or lower?

Mr. THOMPSON. I think it is going to be, but I am not going to be here in 2010. So I can say yes, but you will not any recourse because I am not going to be here in 2010.

Mr. DINGELL. I probably am not either.

Mr. THOMPSON. I hope you are.

Mr. DINGELL. I would observe that we are looking to the future together, you and I.

Mr. THOMPSON. Yes.

Mr. DINGELL. And I am asking your assurances, and you are telling me you cannot give me the assurances.

Mr. THOMPSON. I cannot give you the assurances, but I certainly think that it is going to be much lower. The competition is going to drive it down.

Mr. DINGELL. Let us pray, Mr. Secretary.

Mr. THOMPSON. Okay.

Mr. DINGELL. I am darkly suspicious.

Mr. THOMPSON. I'm a good prayer with you, Congressman.

Mr. DINGELL. Now, Mr. Secretary, I am going to make the following statements. It is important that the seniors know the schedule of benefits and the monthly premium that they are going to hear from the drug coverage that they are going to get, but the law does not specify what either the schedule of benefits, the cost thereof are going to be under the new Medicare proposal; is that correct?

Mr. THOMPSON. I do not think that is correct.

Mr. DINGELL. There is nothing in the statute that confirms——

Mr. THOMPSON. There is nothing in the statute, but we are going to have rules and regulations on——

Mr. DINGELL. Under what authority will you issue those rules and regulations?

Mr. THOMPSON. Under the Medicare Modernization Act, I have the authority.

Mr. DINGELL. Where? Would you please cite us the authority to issue regulations?

Mr. THOMPSON. I cannot do it off the top of my head. It is 1,200 pages long, but I can find it for you.

Mr. DINGELL. Okay. Would you then submit that to us for the record?

Mr. THOMPSON. Sure.

Mr. DINGELL. And, Mr. Secretary, if you would, please, would you also tell us what the level that you are going to fix those premiums at and the schedule of benefits? What will that be?

Mr. THOMPSON. I cannot tell you at this point in time.

Mr. DINGELL. Again, Mr. Secretary, you are putting your finger on why I have dark suspicions on this matter.

Mr. THOMPSON. Trust me, Congressman.

Mr. DINGELL. Mr. Secretary, I trust you, but I do not trust anybody else in the department, and you will understand as my old daddy said, "Trust everybody, Mr. Secretary, but cut the cards."

Now, having said this, Mr. Secretary, is it true or false that the seniors do not need to be informed that private insurers will be able to decide how much seniors will pay for the different drugs?

Mr. THOMPSON. Could you say that again, please?

Mr. DINGELL. I will repeat it. Is it true or false that the seniors under these programs do not need to be informed that the private insurance will be free to decide how much seniors will pay for the different drugs that they will be receiving in these programs? True or false?

Mr. THOMPSON. I think that is true.

Mr. DINGELL. True. Now, Mr. Secretary, under the drug card, I heard much about this. I note that the Medicare beneficiaries cannot change for a year after the choice.

Mr. THOMPSON. yes.

Mr. DINGELL. In other words, the beneficiary can choose the card and he is stuck with that card for a year, but the issuer can change the covered drugs or the amount charged for those drugs weekly. Is that not so?

Mr. THOMPSON. Well, once they lock it in for the enrollment, they are not going to be able to change, but the——

Mr. DINGELL. No, no.

Mr. THOMPSON. We are going to update what it costs every particular card on every week.

Mr. DINGELL. The beneficiary, Mr. Secretary, is locked in.

Mr. THOMPSON. Yes, that is true for 1 year. He is locked in for 1 year.

Mr. DINGELL. The issuer of the card can change those numbers with regard to the amount that the beneficiary pays or the drugs that are covered weekly, and he can change them either up or down.

Mr. THOMPSON. That is true.

Mr. DINGELL. That is true, and that, Mr. Secretary, is regrettable.

Mr. BILIRAKIS [presiding]. The gentleman's time has expired.

Mr. DINGELL. I thank you, Mr. Chairman.

Mr. BILIRAKIS. You are welcome, sir.

Mr. DINGELL. And, Mr. Secretary, thank you.

Mr. BILIRAKIS. The Chair will recognize himself for 8 minutes if I can get this thing.

Anyhow, Mr. Secretary.

Mr. THOMPSON. Yes, Mr. Chairman.

Mr. BILIRAKIS. Regarding the reimportation question, as you certainly know, a lot of the opposition, I like to think virtually all of the opposition to the so-called reimportation of prescription medica-

tion stems from the safety concerns that could arise if the importation of drugs from foreign countries was liberalized.

An argument I often hear in response to these safety concerns, and quite frankly, it makes our position that much more difficult to expound on, is that since there have not been any widespread reports of people becoming ill or dying from taking these drugs, they must, therefore, be safe.

I am aware that under your leadership the FDA has been collecting a great deal of information on the kinds of drugs that are being sent to American consumers from other countries. For example, the FDA or the U.S. Bureau of Customs and CVP, the Board of Protection people have conducted two blitz examinations, as I understand it, on mail shipments at a number of locations last year and found, among other things, that of the 1,153 shipments, 1,153 shipments examined during the first blitz, the overwhelming majority, 1,019 packages or 88 percent, contained unapproved drugs.

And going to the second blitz, of the 3,375 products examined during that second blitz, 2, 256, or 69 percent, were in violation of current law, and an overwhelming majority of the illegal products contained unapproved drugs, but the FDA also found recalled drugs, drugs requiring special storage conditions and controlled substances.

I wonder, Mr. Secretary, can you expand upon the term "contained unapproved drugs"? Can you expand on the recalled drugs, drugs requiring special storage conditions?

Can you tell us roughly, you know, in an approximation sense, of course, of where these drugs might have initiated? Were these Canadian drugs? Were these drugs that were manufactured in Canada?

Mr. THOMPSON. I can answer several of those questions, Mr. Chairman.

These drugs that we had the targeted inspection came from India, came from Thailand, came from Korea, came from South Africa, came——

Mr. BILIRAKIS. Would you say that most of them came from——

Mr. THOMPSON. I would say that the bulk of them came from—the bulk of them came from Canada.

Mr. BILIRAKIS. The bulk of them, they were manufactured in Canada?

Mr. THOMPSON. No, they were not manufactured.

Mr. BILIRAKIS. They were not manufactured.

Mr. THOMPSON. They came from Canada and were——

Mr. BILIRAKIS. Okay. From Canada, but they were manufactured elsewhere Secretary THOMPSON. Right. Unapproved drugs, there was a foreign version of blood thinner, warfarin, which could cause serious bleeding problems; a foreign immunosuppressant, asthenoprene that could cause kidney failure, was one of them. Human growth hormones, which can elevate pressure in the brain were some other ones.

There were controlled substances with high abuse, such as codeine and valium were discovered, and prescription drug abuse in some other categories. There were some animal drugs that were allegedly going to be used for human consumption were also found in a couple of packages. There were several packages that were

mislabeled and several packages that were in a foreign language which were coming into America.

And based upon that it's obvious that I could not certify that these drugs were safe.

Mr. BILIRAKIS. Going to Canada now, and you know, I hate to make it sound like we're picking on the Canadians, and we aren't because they have been great friends over the years; but do they make any efforts to prevent drugs coming from these other countries, manufactured in these other countries from coming into the country, into Canada?

Mr. THOMPSON. I can't speak for Canada. I can only, you know, make speculation that it's probably doubtful. I'm sure that Canada is using their resources effectively, but Canada is such a large country I'm sure it's impossible, just like it's impossible for America to be able to control drugs coming in from all over the world.

We don't have the resources in FDA, and since we don't have the resource in FDA, I doubt very much if Canada does as well. And I don't know for sure, but that's just speculation based upon our experience shared in the United States, Mr. Chairman.

Mr. BILIRAKIS. Well, Mr. Secretary, just sort of playing devil's advocate here, if we don't have any more capacity, if you will to be able to control these drugs from coming from other countries into the United States because we say if we don't here, apparently the Canadians probably don't either, I guess I'm wondering why are we more concerned about these drugs coming in through Canada. I mean, are we concerned about them coming into the United States directly?

I know there have been reports with a growing threat caused by counterfeit drugs within our own domestic supplies; is that correct?

Mr. THOMPSON. That is correct. We are concerned because of the safety matter, Mr. Chairman. FDA is responsible for the safety of drugs, and since we do not have the resources in order to have an inspector in these factories, and they are not inspected by FDA inspectors and the drugs are not manufactured maybe by FDA standards, we cannot certify that they are safe, and therefore, the law does not allow these drugs to come into the United States until the Secretary can certify that they're safe.

Based upon our experience, I cannot make that certification.

Mr. BILIRAKIS. All right, but again playing the devil's advocate, and as you probably know, I did not support the reimportation provisions of the legislation.

Mr. THOMPSON. Right.

Mr. BILIRAKIS. But if that is the case, then we do not have much of a level of confidence regarding our own drugs here; isn't that correct?

Mr. THOMPSON. No. We feel very good about the drugs that are manufactured under FDA standards and FDA approved factories with FDA inspectors. We feel very comfortable about them. That is what FDA does and does it well.

Canada has told us that they cannot certify and will not certify on the safety of drugs leaving their country, and the Canadian officials have told the Commissioner of FDA that.

Mr. BILIRAKIS. Well, but we apparently know that there has been counterfeit drugs within our own domestic supply.

Mr. THOMPSON. That is true.

Mr. BILIRAKIS. We apparently know based on what you have said that a lot of these foreign drugs manufactured in foreign places come in through our borders, not through Canada necessarily. Many come through Canada, but we also know some of them, we say that we cannot protect our borders adequately to catch those.

So I guess what I am wondering is why are we as concerned as we are about them coming in from Canada when, in fact, we know that many of them, and I do not know to what degree, come directly here and not necessarily through Canada.

Mr. THOMPSON. We are concerned about all drugs coming in to make sure that they are safe. The law says that the Secretary is supposed to certify that drugs that are imported into the United States are safe. Based upon our inspections, we cannot certify that they are safe. Therefore, we cannot comply with the law.

If I would certify that these drugs were safe and somebody died, the Federal Government would be held liable, and based upon our information, the safety questions are paramount to us, and we just cannot, you know, set back and do nothing.

So we are trying to tell people if we are going to do it, you have got to give us the resources so that we can inspect the factories that manufacture the drugs and that we have to have FDA resources in order to do so.

Currently, Mr. Chairman, we only have 1,300 individuals in all of FDA to inspect over 56,000 plants and over 200 airports and all of the borders. It is an impossible task for us now to inspect drugs coming into the United States based upon the resources we have.

Mr. BILIRAKIS. Thank you, Mr. Chairman. My time has long expired. Thank you very much.

Mr. THOMPSON. Thank you.

Mr. BILIRAKIS. Let's see. Mr. Waxman would be next, and he has 8 minutes because he deferred. Our problem is, as I understand it, that we have as many as four votes; is that correct?

Well, all right. We will recognize Mr. Waxman for 8 minutes, but in all probably will just cut right after that to go to cast our votes.

Mr. Waxman, proceed.

Mr. WAXMAN. One second, Mr. Chairman. There are going to be five bills.

Mr. Secretary, we know in this country we have 45 to 47 million people running short. We have got a problem that is even getting worse as time goes by, and if we did not have the Medicaid and the child health programs at the State level, we would have far more uninsured than we already have. So these are important programs.

And given the severe budget pressures at the State level because of the economic downturn more than anything else, the States are straining to deal with their own budgets.

Now, what the Federal Government did on a temporary basis was provide extra funding to the States to help pay for their Medicaid programs on a temporary basis. Now, that is going to expire in June. They are still facing those same problems, but the administration did not propose to continue that effort. The administration proposes to let it end and instead in the budget we are asked to figure out a way to cut $10 to $11 billion over 5 years in the Med-

icaid programs, and we have not had a lot of detail as to how we expect this to be done.

We are usually told to eliminate upper payment, limit abuses, inappropriate use of intergovernmental transfers to get these savings, and I want to make a couple of points and then ask you a specific question.

First, this administration and the Clinton Administration put policies in place to eliminate the loopholes in the DSH program, in the upper payment rule limits, and these rules that we put in place had a transition period. They were endorsed by the Congress. They explicitly did not propose to limit intergovernmental transfers which have long been recognized as an important way for the States to be able to fund their program.

The upper payment limit rule was put in place, clearly seen as having adequate protections without interfering in this legitimate and longstanding and long recognized funding source for the program.

Second point. Suddenly the administration has decided to change the rules on the States. You testified before the Senate that you thought 34 States were inappropriately using intergovernmental transfers. Well, that is two thirds of the States of this country, and we are going to tell them now they have got to find some new way to finance their Medicaid programs.

Third point. As you know, intergovernmental transfers, the upper payment limit program, the DSH programs have all been a critical course of funding for the safety net institutions: children's hospitals, the public hospitals, the hospitals that serve a lot of uninsured patients. So if we cut back ten to $11 billion on those recognized ways of helping the States to meet their budget, we are going to cut back on the money for critical health dollars for those institutions.

And fourth, when you came back from Iraq, you've made what has now become an infamous statement that even if you don't have health insurance in America, you get taken care of. Well, that sounds a lot like we would have universal health care in this country, but we do not.

And the truth of the matter is that it has been well documented that there are a lot of adverse health consequences for all of the uninsured people that we have in this Nation.

But I think what you were thinking and a lot of other people, like when the President said he was going to allow more immigrants to come in the Nation in the guest worker program, that somehow these safety net institutions will pick up the slack and provide health care to the uninsured. Yet the proposals that are now recommended to us would absolutely devastate the ability of these health care providers to function.

And finally, I can't help but make this one comment as well. When you were Governor of Wisconsin, you used a combination of upper payment limit rules and intergovernmental transfers. I think it was for nursing home care.

Mr. THOMPSON. I did.

Mr. WAXMAN. And that was to access Federal dollars to help finance your Medicaid program. I say this in no way to be critical because I think it was perfectly legitimate for you to do as for other

States to do, but now it seems like you may be determined to change the rules on the States, and I want to know is it because if you cause continuous disruption for the States in financing their programs they are going to come and give into a Medicaid block grant or is it because you are oblivious to the effect these cuts would have on vulnerable people and the safety net institutions? Is it because this provides you an opportunity to renege on the deal that we had with the States that they were going to get a transition to cope with the reductions in upper payment limit levels, or is it because when you made your own deal when you were Governor of Wisconsin, you think you ripped off the Federal Government?

I do not think you did, but maybe you think you did, and since it takes one to know one, maybe you think you want to make sure that nobody else did what you did when you were Governor of Wisconsin.

Well, this has been a long question, and I have got limited time, but what I really want to know is will you assure the committee that you will provide detailed legislative specifications on the changes you are proposing and an analysis of the impact on each State before we are asked to take any legislative action? Will you do that for us so that the States will know that we have got clearly in mind what the impact is going to be, not the amorphous statement just cut out inappropriate upper payment limits and intergovernmental transfers because we want to know what that means?

Mr. THOMPSON. Congressman, you have made a lot of accusations, and none of them are true, and I would like to be able to respond to them.

Mr. WAXMAN. But first answer my question.

Mr. THOMPSON. Well, I would like to be able to respond.

Mr. WAXMAN. No, first answer my——

Mr. THOMPSON. You made some accusations. I think I have a right.

Mr. WAXMAN. Well, I think you should be able——

Mr. THOMPSON. I think I have a right to respond.

Mr. WAXMAN. I think you do, but first I only——

Mr. THOMPSON. First, I think I have a right——

Mr. WAXMAN. Mr. Chairman, I have——

Mr. THOMPSON. [continuing] to respond.

Mr. WAXMAN. [continuing] the time, and my question is very specific. I want a yes or no.

Mr. THOMPSON. Am I allowed to respond?

Mr. WAXMAN. Give me an——

Mr. BILIRAKIS. Let's give the gentleman the time to respond.

Mr. THOMPSON. There were several personal accusations, and I would like to be able to respond.

Mr. WAXMAN. I want you to, but I want a yes or no. Will you give us detailed legislative proposals?

Mr. THOMPSON. I always give you details. You have requested 31 pages in the last year, 31 different requests. My department has given you 21 answers. We are working on the——

Mr. WAXMAN. I am not talking about me personally. All of the members ought to be able to have it.

Mr. THOMPSON. I would like to be able to respond to you accusations because——

Mr. WAXMAN. So please proceed.

Mr. THOMPSON. [continuing] they are false.

Mr. WAXMAN. Please proceed.

Mr. THOMPSON. They are absolutely false.

Mr. BILIRAKIS. All right. Let's do what we can here, but the fact of the matter is we are——

Mr. THOMPSON. Intergovernmental——

Mr. BILIRAKIS. [continuing] going to have to break to go for a series of votes. Go ahead, sir.

Mr. THOMPSON. Intergovernmental transfers are legal if they are done legal. There is a law that says that when the Federal Government gives a proportionate share, the State has got to participate.

The State plans that are coming in have got differences. The State plans are not paying their share, and I do not think that is fair. When I used the intergovernmental transfer, I paid the State of Wisconsin's share to get the Federal share.

Here are some examples. A State made upper payment limits, quarterly payments via electronic transfer to a nursing home bank account. The State then immediately withdrew the amount of the payment from the provider's account less a $2,500 participation fee.

If they would have left it to the nursing homes, that would have been legal, but it did not go to the nursing homes. That money went back to the State. Therefore, it is illegal, and I think that is not fair.

Therefore, the Federal Government is paying more to that State than the State share.

Second example. Made supplemental payments to all nursing facilities upon receipt of the payments, the nursing facilities are required to return 99.5 percent of the payment back to the State. If the payments would have stayed with the nursing homes, it would have been legal. They came back to the State to be used for other things.

I don't think you would approve of that because you, like myself, want to make sure that money goes to take care of poor people.

The third State. Made supplemental payments to county nursing facilities. As a condition of receiving these payments, the nursing homes must sign a participation agreement in which the nursing home agrees to return all but $10,000 of the payment. Nursing homes are allowed to keep the $10,000 as a participation.

Mr. BILIRAKIS. mr. Secretary, would you hold up? Listen, we have got to catch this vote. I am not sure whether Henry cares, but I do. I do not want to miss the vote.

So I am just going to recess until approximately 4 p.m., four o'clock, maybe five after four, something of that nature, and then you can continue, sir.

Mr. THOMPSON. Thank you.

Mr. BILIRAKIS. Thank you.

[Brief recess.]

Mr. NORWOOD [presiding]. The committee will come to order, please.

Mr. Secretary I apologize for the delay. You are very kind to remain with us.

And now I recognize Mr. Whitfield for questioning for 8 minutes.

Mr. WHITFIELD. Mr. Chairman, thank you very much. I appreciate that.

Mr. Secretary, we appreciate your patience.

Last year, around September or so, Dr. Teresa Mullen, who is the Associate Commissioner in the Office of Planning and Evaluation for FDA testified before our committee, and also Dr. Anna Barker from the NCI similarly testified, and they talked about a task force between the National Cancer Institute and the FDA oncology group of the task force, the purpose of which is to improve communications between the two agencies to expedite bringing new technology and drug therapies to patients and physicians for treatment.

And they were quite optimistic about the process that this task force was making, and they were particularly keen on the fact that it would simplify that entire process.

But I have been involved with one particular company from a standpoint that I have a dog that has been receiving therapy that is experimental, and they are getting ready now to go for human trials, and we are concerned, and we do hear from small and medium sized biotechnology companies that the lack of effective communication and coordination between the FDA and the National Cancer Institute impedes the transfer of new, innovative therapies out of the laboratories and into the hands of treating physicians.

For example, in this instance, FDA is requesting certain toxicological studies that have already been conducted in another type of experiment, and the whole process is slowing down what appears to be even by surgeons at NCI, at the National Cancer Institute, a really promising therapy to address cancerous tumors.

And I was wondering if you would have any comments at all about what your view is on how effective this task force has been in trying to break down some of the obstacles in bringing these treatments to the marketplace.

Mr. THOMPSON. Well, Congressman, we can always improve and we need to improve. The problem has always been that the efficacy of the drugs plus the safety, and to try and get the efficacy requires a great deal of time, and then you want to make sure that the drugs are safe.

The coordinating committee is working, and the nice things that we have been able to do with FDA and NIH is to look at ways in which we can get these drugs to the market faster, and we are trying to work on that.

We are already improving, but I am still not satisfied, and Dr. McCullen is not satisfied, and neither Elliot Zerhouni. So we continue to meet. We continue to collaborate, and I am confident that we are going to see some improvements, some vast improvements in the future, and I appreciate the question.

Mr. WHITFIELD. And on March 5, I wrote you a letter spelling out a specific incident in more detail, and I do look forward to getting a reply. I know you receive many, many letters, but that will even address it more. So I would appreciate your consideration of that.

Mr. THOMPSON. Congressman, we try to answer all of the letters.

Mr. WHITFIELD. thank you.

Mr. THOMPSON. Nobody has been quite as prolific as Congressman Waxman, but we try to comply very much with every request, and we will get your answer as soon as possible.

Mr. WHITFIELD. Thank you.

Mr. Secretary, this committee had a hearing or one of our subcommittees had a hearing recently on prescription drug monitoring programs, and the first prescription drug monitoring program in the country was established in 1940 in California.

And since that time we only have about 17, 16, 17 programs operating in the country right now, and all of the witnesses testified to the significant problems that this is causing our country, the improper use of prescription drugs.

And the request I would ask you is because in the 64 years that we have tried to get this program, it is still not in every State, not close to being in every State. Would you, from your perspective, consider a Federal approach to establishing a prescription drug monitoring program?

Mr. THOMPSON. Yes, buy let me quantify that. Right now we are so completely overburdened with getting the Medicare Modernization Act implemented that it would be pretty difficult to take on another program like that at this time, but if Congress saw fit to pass it, we certainly would be more than willing to do it.

But right now, with FDA, with looking at the investigatory committee on importation of drugs, we are setting up a new commission to take a look at that.

Second, the implementation of the Medicare, getting the drug card out, all of these things are just straining us to the nth degree.

So I would say yes. I think it is the right direction, but at this particular point in time I don't think we could do it.

Mr. WHITFIELD. Mr. Secretary, thank you.

And I yield back the balance of my time.

Mr. NORWOOD. Thank you very much.

Mr. WAXMAN. Mr. Chairman, I do not think it would be fair to Secretary Thompson not to be able to fully respond to me. So if he wants to respond further for the record——

Mr. THOMPSON. I would love to.

Mr. WAXMAN. [continuing] I would welcome it.

Mr. NORWOOD. Unanimous consent.

Mr. WAXMAN. And second, I would hope he would also be very specific and answer my question, which is whether we are going to get a detailed analysis of any legislative proposals.

So if we could keep the record open for a response to my question and get further comments on areas where he thinks he——

Mr. NORWOOD. Mr. Waxman, would 2 minutes be sufficient do you think?

Mr. WAXMAN. Well, we can do it for the record.

Mr. THOMPSON. Congressman, I would like to be as quick as possible. You made several what I consider accusations that were not correct. I think you and I agree that the money that goes from the Federal Government should go to the providers so that they can provide to the people that need the service, not back to the State.

I believe that there is a correct way to do IGTs, and that is to continue to provide for those local units of government, local hospitals, local institutions to pay the State's share, provided the

money then goes to those individuals for the care of the poor people. That is not happening, and that is the big problem, and that is what we are trying to stop. And those are the questions.

It is exacerbating, and that is why I am bringing it to the attention to you and to the members of the committee, and I gave you several examples of that, and I am not going to mention States because I do not want to go into individual States because I do not think it is fair.

We are trying to negotiate with the States, and hopefully we can reach an agreement. All of the States that I have talked to have said, yes, it is not the way to do it, but we have done it this way before. Other States are doing it. Now we want to be able to get into this particular program, even though we know it is not correct.

And so a lot of the money is being sent to the State. The State sent it down to the counties, and then the counties have to remit the money back to the State, and the State puts it in the Treasury.

Mr. WAXMAN. Mr. Secretary, with the last 30 seconds, the examples you gave I thought were good examples of what we do not want to permit.

Mr. THOMPSON. That is true.

Mr. WAXMAN. They also are examples of upper payment limit abuses that I thought we had taken care of in the regs. We want to work with you, of course, to stop any improper actions.

Mr. THOMPSON. Thank you.

Mr. WAXMAN. But we are being asked to cut $10 to $11 million out of the Medicaid Program, and before we do that, I would like you to assure not me but the committee that you will provide detailed legislative specifications on the changes that you are proposing and an analysis of its effect on each State. I think that is fair to ask, and I hope that you will comply with that.

Mr. THOMPSON. We will do it to the best of our ability, Congressman, as we always try to do. I just think that a more fair way would be if this committee and Congress wants to give the States more money, put it into the FMAP so that every State is treated equitably instead of trying to use a dodge in order to get more money from the Federal Government and the money goes to the State, and it does not go to the people that we——

Mr. WAXMAN. Would you support an increase.

Mr. NORWOOD. Thank you, Mr. Waxman.

Mr. Waxman, if you will submit that for the record, the Secretary has to leave at five o'clock.

Mr. WAXMAN. I understand.

Mr. NORWOOD. And a lot of members want to ask question, and with that in mind, I am going to keep us right at 5 minutes.

Chairman BARTON. Mr. Chairman, can I briefly comment on that, too, before we go on?

Mr. Secretary, we are going to work with you on that. Mr. Waxman raises a valid point, but there are some of us in the majority that feel like the point that you're raising are issues that need to be addressed, and we want the money spent the most wisely, and we do not think it is fair that some of these games have been played.

Mr. THOMPSON. thank you.

Chairman BARTON. And so we will work with you.

Mr. THOMPSON. thank you very much.

Mr. NORWOOD. Just a reminder. We will keep you right at 5 or 8 minutes according to what you have coming, and with that, Mr. Brown, you are recognized for 3 minutes for questioning, plus 2 minutes for going over, for a total of 5 minutes.

Mr. BROWN. Three plus 2. Okay. Got it.

Thank you.

And I was intrigued, Mr. Secretary, by your and Mr. Bilirakis' back-and-forth on the safety of reimportation. I also appreciated Mr. Dingell's method today of true/false. I have one true/false question, and then I would like to get into more substantive.

True or false, no drug imported into this country is FDA approved unless it is imported by the manufacturer, correct? No drug imported into the United States is FDA approved unless it is actually imported by the manufacturer, correct?

Mr. THOMPSON. True.

Mr. BROWN. Okay. That is my understanding, too.

Earlier when you said the administration's view of imported drugs found that most of the drugs you audited were not FDA approved and were, therefore, unsafe, it is a bit of a Catch-22. So if a drug is not FDA approved, it cannot be used as a proxy for safety. So my question goes more to this, that Mr. Bilirakis and you talked about how important or, I mean, whether your contention seems to be many, many of these FDAs and many of these drugs have been unsafe.

Our contention, by many people on my side of the aisle, but many Republicans, too, is that these——

Mr. THOMPSON. That is true.

Mr. BROWN. [continuing] drugs that are coming from other countries are, in fact, safe. As Mr. Bilirakis said, we are not seeing people dropping dead in Canada, France, Israel, Germany and Japan that are using a good safety process.

Now, if the drugs are as dangerous as you say they are, that information is so very, very important for Americans to know. If drugs are as safe as we think they are, based on the high cost of drugs, the fact I have bus loads of people that I have taken to Canada, that many others in my community are doing the same thing; if they are as safe as we think they are and the demand is so high for people to save money, if that is the case, both of those statements, then the American people deserve to know sooner rather than later what, in fact, your conclusion is.

It is pretty clear that, you know, reimportation has already passed the House. The other body may be considering legislation. We need information here. It is obvious from your testimony that the Bush Administration has done considerable work on this issue. Otherwise I am sure the administration would not have felt comfortable vocally opposing the reimportation bill as he did last year.

So my point is, Mr. Secretary, we need you to finish this work sooner rather than later. The requirement in the bill is December for you to complete your work. Can you commit to us an earlier date so that Congress can move on this issue by the summer?

Mr. THOMPSON. I think you are absolutely correct, Congressman, and I am going to try and get it done a lot sooner. I would like to get it done as soon as possible. We are going to have our first meet-

ing next Friday, and we are having—I have got the list of the people that were invited.

We have invited most of the people that are pro reimportation. Individuals that are for it are going to be testifying, and the first public hearing is going to be next Friday, and we have already sent out notices, and we will be.

And I also wanted to point out that I am not going to designate Mark McClellan as chairman. The last hearing I was at several people on your side of the aisle decided or indicated that that was not fair, would not be considered, a very unbiased conference. So we are putting somebody else in as chairman. I will be making that known some time tomorrow or the next day.

Mr. BROWN. Can you commit to an earlier date or at least suggest can we have it by July 1? Can we have it by June 15? Can we move this more quickly so that on the one side we——

Mr. THOMPSON. I hate to give you a date, but I can commit that we are going to push to get it done before December 1, Congressman.

Mr. BROWN. Will it be several months? I mean, I do not want to push too much, but will it be several months before December 1?

Mr. THOMPSON. I would like to see it done some time this summer.

Mr. BROWN. Okay. Another real quick question. The administration and Congressional Budget Office have varying estimates of the cost of Medicare law, as we know. Could you tell me how much your actuaries estimate that reimportation saves? Do you have a figure for us?

Mr. THOMPSON. I do not have a figure on that. I do not think my actuaries have made any assumptions on that, but if they have, I can get that information.

Mr. BROWN. I would request that they do. That is pretty important information in judging the whole point of reimportation, if you will.

Last point, Mr. Chairman. I have about 20 seconds. The President's total request for the HIV/AIDS, TB and malaria bilateral spending for 2005 went from $1.8 billion in 2004 to $2.6 billion in 2005. The President's request, as you know, would cut the U.S. contribution to the Global Fund from $550 to $200 million next year.

As chairman of the Global Fund, what are you telling the President?

Mr. THOMPSON. Right now that is all we can give, Congressman because the law passed by you puts a limit as to how much the United States government can give. It is limited to 33 percent.

The cash on hand right now is about 39 percent that the United States has given. So we cannot even given the $200 million right now unless more countries come in and contribute to the Global Fund.

But I can tell you that the Global Fund is doing well. We are in 121 countries, have got 225 projects going, and I am going to Geneva next week to chair the——

Mr. BROWN. So that means if we can get private money, philanthropist money, and other governments' money our number will go up? Is that as assertion you are making?

Mr. THOMPSON. Well, right now we cannot contribute anything because we are above the statutory limits.

Mr. BROWN. Right. I am saying if they can do more we can do more? We will do more?

Mr. THOMPSON. I think that there is a strong possibility, Congressman.

Mr. NORWOOD. Thank you very much. The gentleman's time has expired.

Mr. Upton, you are recognized now for 8 minutes requested.

Mr. UPTON. Thank you. Thank you, Mr. Chairman.

Mr. Secretary, welcome. I do not know if you have had a chance to see the "Families USA" movie. Some of us have been able to see it, Walter Cronkite, some other folks. In my estimation they do a very good job of trashing the prescription drug bill.

Have you had a chance to see this? It is about a 17 minute clip, and I understand that they are sending it all across the country.

Mr. THOMPSON. I have not seen it. I have heard about it, Congressman, but I personally have not seen it.

Mr. UPTON. When I saw it, there was a part there where they talk about the discount card that will be available a little bit later this spring, and in essence they make the point that it is a bait and switch program; that a senior signing up for this will get the card, and every 7 days the provider of that card can change it. They can change the prescriptions. They can change the discount.

So if you have whatever particular ailment one might have, and maybe pick a specific plan because of the benefits from there, it can change literally every single week. Is that going to be something that the department is going to allow to happen?

Mr. THOMPSON. No, it is not, and I am glad you asked me. I could not explain that to Congressman Dingell because he only allowed me to have a true or false. And it is partially true, but——

Mr. UPTON. Well, I have got my 8 minutes.

Mr. THOMPSON. [continuing] it is more false because we have already passed a rule and have indicated that we will revoke cards that are issued if they are bait and switch. It is already in our rule. It is also going out into our contractual arrangements with the card companies.

Mr. UPTON. Well, that is very good to hear because I can tell you——

Mr. THOMPSON. That is already. We have already proposed that.

Mr. UPTON. [continuing] as I sat down and watched this, I was just shaking my head, and I was hoping that you would have an answer like that.

This weekend when I was back in Michigan, I went to a pancake breakfast, and I met a wonderful lady who sadly has lupus, and she now has to spend she told me $700 a month in added costs that she is going to have to pay, and she asked me specifically about whether the prescription drug bill the President signed, is that going to help her.

Mr. THOMPSON. It is going to help her a lot.

Mr. UPTON. And that is what I told her. And, again, looking at this "Families USA" film clip was a very biased report. It talked about all of the cost. It did not say a single thing about a benefit. It is almost like it is a new tax, and the thousands of dollars that

they are going to benefit from that they are going to be able to be charged and not receive a single benefit as I saw with this particular woman this weekend.

One of the things that I liked in the prescription drug benefit bill was the benefit that is going to be provided to companies that provide prescription drugs to Medicare eligible seniors, the subsidy that those companies are going to receive. The statistic that I saw was that the percentage of large firms having more than 200 workers that offer retiree health benefits has declined from 66 percent in 1988 to 34 percent in 2002.

My sense is that with the adoption of the prescription drug benefit bill, that we will stop that decline that we have seen over the last 12 years.

Mr. THOMPSON. We certainly believe that it is going to be a tremendous help in either stopping or slowing down completely those companies that drop drug coverage for their retired employees. We think it is a very good provision, 28 percent subsidy for those companies that give drug coverage to their retirees.

Mr. UPTON. Have you heard about any report since the enactment of the bill where companies have indicated that they are going to drop their prescription drug benefit for their retirees and maybe pay the doughnut hole or just shift everybody into the new plan and perhaps pay the out-of-pocket costs that the beneficiaries would receive as a saving perhaps to them? Have you heard about any companies that would do that?

Mr. THOMPSON. Companies right now, I think, are still making up their minds.

Mr. UPTON. I know it does not kick in until 2006.

Mr. THOMPSON. I think they are still making up their minds as to what they are going to do, but I have heard good responses back from companies who have indicated that this subsidy that you passed and the President signed into law is going to help them to be able to continue drug coverage for their retirees.

Mr. UPTON. You know, one of the arguments coming from a Midwest State like you do, we have seen a lot of jobs outsourced for lots of reasons, one of them being the high benefits perhaps that U.S. firms have to pay versus what is paid in other countries, and as I talk to the auto sector, one in seven jobs being auto related, I believe that one of the Big Three indicated that they spend $1.1 billion in prescription drug benefits to their Medicare eligible retirees each year.

Now, my sense is that when this bill kicks in for seniors, that in fact that company will be able to get a check tax free for what was it, 25 percent?

Mr. THOMPSON. Twenty-eight percent.

Mr. UPTON. Twenty-eight percent of what they pay? So, in essence, nearly, you know, hundreds of millions of dollars that they will be able to use for the benefit costs here and thus, have a better chance of retaining those jobs in America versus sending those jobs overseas.

Would you agree with that?

Mr. THOMPSON. I would agree with that, and I also would agree further and even more plausible is that that company will more

than likely keep that drug coverage for the retirees, and without these subsidies would not.

Mr. UPTON. That is exactly right, and you know, as I read and sign all of my mail, I heard from a whole number of folks who were scared that this plan passed and enacted now by the Congress, that they would be forced to go into an HMO. I remember we had that debate early.

You made the point in our first hearing, I think, 2 years ago, saying that that was not going to be part of the package. That was not agreed to, and that it would be a positive benefit for those workers.

Mr. THOMPSON. That is correct. It is positive. It is a very good bill. It is not perfect, but it is a very good bill.

Mr. UPTON. When is the date that you are anticipating getting the discount card available for seniors and how exactly is that going to proceed?

Mr. THOMPSON. People are going to start being able to enroll in a discount card on May 1 through the whole month of May, and we are going to start the program starting June 1. The companies are going to be able to get out information, and with their discounts.

We are going to put it up on our Web page, and it is going to be a transparent page so that everybody can find out exactly what this company is going to be charging for their drugs. Every senior citizen can call in.

A senior citizen like this woman with lupus could call into 1-800-MEDICARE and be able to say, "These are the drugs I am talking. Please tell me which drug companies are going to give me the best deal," and we will be able to give her that information. We will have all of that information on line, and we will be able to tell her exactly where she should go.

Mr. UPTON. And will she be able to go to a Walgreen's or I mean a whole variety of different pharmacies to have her prescription filled?

Mr. THOMPSON. Well, it depends upon the——

Mr. UPTON. Medco? I mean how exactly will that work in terms of where she would go.

Mr. THOMPSON. Well, the companies that have got to issue the cards have got to sign up the pharmacist, but we are going to have that information. So we can tell her, this individual that has lupus; we will be able to tell her which of these drug card companies are going to give her the best deal for her drug charges, plus where the closest drug stores are to her.

And they have to be, if she is in an urban area, have to be within two miles of her residence, or if she is a suburb, it has to be within five miles of her residence. So we are going to have all of this information, and we are going to also have a lot of information into the community by the SHIPS program to be able to help advise, plus this individual can call us and give this information right away.

Mr. UPTON. Thank you.

Mr. NORWOOD. Thank you, Mr. Upton.

Mr. Pallone, you are now recognized for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. Secretary, my questions are about the Indian Health Service, and let me just say by way of background that I think that the amount of money that is being allocated to the Indian Health Service is woefully inadequate. I mean, the number of American Indians that need health care and do not have access to it, you know, continues to go up.

Frankly, when you look at some of the recommendations that were made by the tribes in terms of the amount of money that they think is necessary, it would be four or five times what is actually allocated.

But I had specific questions. I am going to try not to have them be true/false, but I have four questions I am going to try to get through if I can.

First of all, in the budget the budget request is $2.97 billion for the Indian Health Service, an increase of only 1.65 percent, or $45 million, over the last fiscal year. I mean, my understanding is that inflation is running like 3 percent or more right now. So when you are talking about, you know, less than half or half of the cost of inflation, obviously you are going to have to do less, not more, even though the need is great.

So I basically wanted to know if you would support additional funding if, you know, somehow the appropriators could find it and, you know, how the administration justifies this effective decrease in funding for the Indian Health Service.

Mr. THOMPSON. Congressman, as a department, we were given the amount of dollars that we had. You will notice that Indian Health Service got a higher percentage than most of the other operating divisions in my department, which indicates my desire to put more money there, but still, if you could find more money, we certainly could use it, especially in a program that I think is very important. It would improve the quality of health, and that is in the water and sewer systems in Indian Health.

I go to Alaska every year, and I know that there is a tremendous need.

Mr. PALLONE. Okay. I appreciate that. I am just trying to get through these four questions.

Mr. THOMPSON. Okay. I am sorry.

Mr. PALLONE. That is all right. I appreciate it.

The second this is the contract support. As you know, many of the tribes have taken over their own health services.

Mr. THOMPSON. That is true.

Mr. PALLONE. And I know that this administration has encouraged that, you know, I guess in part for ideological reasons, because it means that the government is somewhat out of the business.

But if you look at the budget, it is basically flat. In other words, there is $267 million, the same as last year, to support, you know, these contract support, which probably means that no additional tribes would be able to do it.

So, again, you know, the question is if we were able to find funding, would you support an increase for that and why the administration just flat funded that.

Mr. THOMPSON. Well, I do not know where you are getting that. It is my understanding the contract health service went up $18 million, about 4 percent increase.

Mr. PALLONE. Okay. Well, I see it is 267, the same as last year. So, you know, I am not going to disagree with you. I have to go back and look at the facts again.

Mr. THOMPSON. Okay.

Mr. PALLONE. But obviously, is that something——

Mr. THOMPSON. So will I.

Mr. PALLONE. Is that something that you would be willing to see if we could find some additional funds that we would increase that as well?

Mr. THOMPSON. Yes, we could use the money.

Mr. PALLONE. Okay. Then the third thing is, you know, the tribes are concerned about homeland security and the fact that they do not seem to be designated for specific homeland security funds, and there is, I guess, $476 million, you know, for your department related to homeland security I guess for bioterrorism attacks through the Health Resources and Service Administration, but there is nothing specifically earmarked for the tribes, and that has been the case with homeland security funds in general.

So I do not know if you can tell me, but if not, maybe you could get back to me about whether any of these funds would be allocated to tribal governments.

Mr. THOMPSON. I know that they are eligible for them, and I know they are eligible for bioterrorism funds, the tribes, and I will take a look at it and give you a direct response as to what portion are going to Indian——

Mr. PALLONE. But, I mean, obviously you would support some portion of it going to them.

Mr. THOMPSON. Yes.

Mr. PALLONE. Okay. And the last thing, it is my understanding that the Resources Committee, Representative Pombo, has requested the administration's policy position on the Indian Health Care Improvement Act, the reauthorization, and you know, this is very important. It is before this committee as well as Resources. It is within the jurisdiction of this committee as well.

And I just was wondering if you could tell me when we can expect to hear back from the administration or if you wanted to comment on your position on that reauthorization because we are trying to get it passed this year.

Mr. THOMPSON. I cannot respond right now because it is something I am——

Mr. PALLONE. Well, if you could get back to me.

Mr. THOMPSON. I will get back to you.

Mr. PALLONE. With the permission of the chairman, if you could respond to me in writing or if you have something there about when we could hear back.

Mr. THOMPSON. I just received a note from my legislative assistant who has told me that she is working very closely with the Hill, and she expects that very soon.

Mr. PALLONE. Okay. Within a month, a few weeks?

Mr. THOMPSON. She says a month.

Mr. PALLONE. Okay. I appreciate it. Thank you.

Mr. THOMPSON. Thank you.

Mr. PALLONE. Thank you, Mr. Secretary.

Mr. THOMPSON. I will get you that information, Congressman. I appreciate it.

Mr. PALLONE. Okay.

Mr. NORWOOD. Thank you, Mr. Pallone. Your time has expired. I recognize myself now for 8 minutes.

Mr. Secretary, when we first went around, I did not have time to say to you how much I appreciate you spending the amount of time that you are here in this great committee and also how much I appreciate the job you have done at HHS over the last 3½ years.

Mr. THOMPSON. Thank you.

Mr. NORWOOD. You have, I think, probably the most customer friendly agency out there, and that has everything in the world to do with who the boss is, and I am grateful for the work you have done and not happy you are leaving at the end of the year.

I was not going to ask about prescription drug monitoring, but it came up, and I think we need to talk about it just for a second.

Mr. THOMPSON. Sure.

Mr. NORWOOD. The problem in this country is more acute today, obviously, than it was 50 years ago, though there was a problem 40, 50 years ago, and there is movement up on this Hill to let's try to get hold of this problem and see if we cannot do something about it.

The States obviously have not done anything about it over the years, which is not an indication that they do not want to or cannot. It is probably an indication of the cost, and I have observed, as some appropriators have found a few funds here and there, some States are getting better at it.

My personal believe is that that program would be best run by State governments, grants from the Federal Government with a floor, basic standards of what a drug monitoring program should be, and let States not have the one size fit all situation. I know as a Governor I would guess you would sort of be inclined to think that way.

The Director of the Office of Drug Control Policy, they recently had a press conference about this, and he said that their goal is to expand the number of States who have drug monitoring programs up to 30. My goal would be to get it up to 50 and where they could cross lines.

As a former Governor, would you care to comment on whether you think practically you might do this best at the State level rather than the Federal Government, one size fits all?

Mr. THOMPSON. Well, Mr. Chairman, you are always on the cutting edge with your philosophy and your ideas, and I certainly think it is the best way. I always think that if you can get the decisionmaking back to the States you are going to be better off and you are going to be able to have a better and a more efficient program. It just makes sense.

In this case, I think you are absolutely correct.

Mr. NORWOOD. Well, thank you.

We need to get this done, and we do not need to fight too long over whether it is State or Federal, but I believe we would have a country-wide better program being State.

I think maybe the first time you and I had discussions, it was right after you came into office, and we were looking at HIPAA and the medical privacy regulations left us by the former administration, and I do not know a lot, but I had enough sense to know that thing was going to waste a lot of money in health care if it had not been altered, which you did some, and it was better.

But still there were problems in medical privacy, and you have been working on those, I understand over the last months, and I would like for you just very quickly to bring us up to speed a little bit about some of the changes that have been made and, second, how are we educating the people that are involved with those changes.

Mr. THOMPSON. Well, let me answer the second part first. We are putting out as much information as we possibly can, and when we see a complaint, we call those individuals, that hospital, those lawyers, or we set out a delegation to go out into that community or that State and set up informational hearings. We are doing that all over the country.

Most of the problems with HIPAA right now are miscommunications and not understanding what we have done to make the changes. As soon as we hear a complaint, we immediately go out there and talk to them and find out what we can do to alleviate that problem, and usually just by educating and talking to them, we have been able to quell the kind of concerns that they have.

I would have to say to you I have spoken to the Hospital Association, Medical Association. Hardly any questions at all any more about HIPAA, which indicates to me that it is working the way we thought it would, but if you have some other complaints, I wish you would give it to me.

Mr. NORWOOD. No.

Mr. THOMPSON. And I would be more than happy to continue to work on it.

Mr. NORWOOD. I only mean our difficulties in coming down on that, too, but I want to make sure that the people that are involved in this, the people that are treating patients have enough information to know the good changes you made.

Mr. THOMPSON. Thank you.

Mr. NORWOOD. Now, one last, quick question. I know this will probably be a real surprise to you that I did not vote for the Medicare prescription drug bill, but I did not, and I did not vote for the bill for the opposite reasons some of my other friends did not vote for the bill. Some people did not vote for it because they think it did not spend a trillion dollars. I did not vote for it because I know it is going to spend a trillion dollars.

And so where I am in the thing is it is probably the best prescription drug bill I have seen sine we have been up here. We have not had a lot to choose from. It is the law of the land, and I am going to do everything I can do on a personal basis at home to make sure that my constituents understand.

This bill may not be great for taxpayers, but it is pretty bloody good for the patient.

Mr. THOMPSON. It is very good for low income Americans.

Mr. NORWOOD. Well, it is also good for sick Americans.

Mr. THOMPSON. Right.

Mr. NORWOOD. Very sick Americans.

Just in my last 2 minutes, the prescription drug card that is coming out, that is the first card we are going to use, $30 for the thing, $600 credit on it for low income. You said you had 151 hit son that?

Mr. THOMPSON. No, we had 150 different entities want to issue the card.

Mr. NORWOOD. That is what I mean. That is what I meant by that.

Mr. THOMPSON. Yeah, 105.

Mr. NORWOOD. So that is 151 companies out there who have called you up and said, "Mr. Secretary, I can furnish that card"?

Mr. THOMPSON. That is correct. One hundred and five.

Mr. NORWOOD. One hundred and five. How many will you boil it down to?

Mr. THOMPSON. We are working on that right now. In fact, I told my staff I want to get it down by Friday. We are looking somewhere in the neighborhood of 40 to 50. You have got to break it down because some are national, some are regional, and some are for Medicare Advantage Plans. Some people just want to enroll their own members, and for those that want to just enroll their members that are HMOs or Medicare Advantage or Medicare Plus, we are going to allow them to do it provided they have the solvency in order to do so.

Mr. NORWOOD. So you at HHS are actually going to help people to determine under your circumstances this is the best card perhaps.

Mr. THOMPSON. Absolutely. It is going to be completely transparent, and we are going to allow individuals to call in with their prescriptions and tell them which one of these cards is going to give them the best deal and where the closest drugstore that this particular card company has enrolled for that individual.

Mr. NORWOOD. So every card, let's say there ended up there are 40. Every card will not have the same savings factor in it.

Mr. THOMPSON. Not all of them will be because some will make better deals with the companies, and we are going to have those listed, and we are going to be able to advise every applicant that wants to enroll which is the best card for that particular person compared to the prescriptions they are taking.

Mr. NORWOOD. Well, people should not say this prescription drug bill absolutely does not help anybody. That is really a false statement.

Mr. THOMPSON. It is.

Mr. NORWOOD. And there are some very, very good things in it that I am glad are in it, though I am still concerned about it, therefore voted no. But all of us ought to be out there at home trying to help our seniors understand what the law of the land is and then trying to improve that anywhere we can over the next few years.

Again, Mr. Secretary, my time is up, but I cannot thank you enough for your services.

Mr. THOMPSON. if I could just quickly say that one of my staff people briefed you last fall about the simplified fact sheets, and you requested that they be simplified further.

Mr. NORWOOD. Yes.

Mr. THOMPSON. They are on the Web page right now pursuant to your instructions.

Mr. NORWOOD. Thank you, sir.

And I want to make sure everybody in American who uses that knows it.

Mr. THOMPSON. It came from you.

Mr. NORWOOD. Well, you fixed it though. I may have asked you to, but you fixed it.

Mr. THOMPSON. We fixed it.

Mr. NORWOOD. Ms. Capps, you are now recognized for 8 minutes.

Ms. CAPPS. Thank you, Mr. Chairman, and thank you, Mr. Secretary.

It is not every day that morning news leads with a health topic. Tragically this morning, I think ominously, the CNN led morning news with the statement and the fact that within a very short time obesity will be the No. 1 underlying cause of death in this country, and I want to compliment you for getting out early on that topic.

This is not what I am going to use my 8 minutes on, but I just want to make a statement.

Mr. THOMPSON. Thank you.

Ms. CAPPS. You saw this coming, and it is a huge challenge.

Mr. THOMPSON. Huge.

Ms. CAPPS. And I think your ads, I have seen two of the ads, and they are great.

Mr. THOMPSON. Thank you.

Ms. CAPPS. I know that is not going to solve the problem by itself, but it is a good statement to get out there.

Mr. THOMPSON. Thank you.

Ms. CAPPS. It is getting people talking about it.

Mr. THOMPSON. I am glad you saw the ads.

Ms. CAPPS. I would like to get back to revisit, since you offered to be here, the newly enacted Medicare program, and according to MEDPAC, Medicare is in this new plan paying private plans 9 percent more than the amount it would cost to cover the same mix of enrollees under Medicare's traditional fee-for-service system.

Now, CMS through regulation has implemented a risk adjuster and budget neutrality provision that increases payments by 16 percent. It is expected that CMS will be changing this risk adjustment factor to 8 percent, and that means that plans will be paid a total of 117 percent of what it would cost to cover the same mix of enrollees under Medicare's traditional fee-for-service system.

I noticed that you acknowledged this fact that Medicare pays HMOs more than it would cost to serve those beneficiaries in fee for service when you testify to Ways and Means on February 10. So that I could get it really clear, I am going to quote now from the transcript.

Mr. Kleczka asked, "Do you agree that currently we are reimbursing HMOs and PPOs who administer to Medicare patients higher than under the Medicare fee-for-service program?" And you did acknowledge yes. My question is: if plans are so efficient and

we are choosing the private sector because of their efficiency—I have heard that—why do we need to pay them 17 percent more to provide the same services under a private plan? Why should we pay private plans more to provide services that would be cheaper, demonstrably cheaper, in traditional Medicare?

Mr. THOMPSON. I do not believe we are paying them 17 percent, but we had put together a plan, Congresswoman, that asked Congress to pass so that the lowest three individual bidders would be the ones who would be accepted, and our actuaries believed that would have driven down the price below the fee for service, and that was what we did.

Congress made a decision that said, no, we should not limit it to the three lowest bidders. It should be wide open, and as a result of that, there is not the pressure to drive down the prices. As a result of that, there is the possibility based upon our actuary that we will be paying more for HMOs.

Ms. CAPPS. In addition, the administration estimates that $46 billion, CBO estimates $14 billion, will be pumped into HMOs under the new Medicare law over the next 10 years. In your testimony you state that this money is going to be used by Medicare Advantage to provide more generous coverage, including benefits that traditional Medicare may not offer.

Accordingly, we have seen that HMOs have been courting seniors in different areas. For example, the New York Times article showed Humana according the same seniors that they had left hanging in Florida in 2000 when the very same plan pulled out.

Now, I agree with you that seniors should receive more and better services, and I would be more than happy that these services would also be provided under traditional Medicare, but I think it is only fair that it be on a level playing field.

Again, we are going to be paying private plans more—we can quibble about how much more, but estimates state 17 percent—to provide the same mix of services that it costs under traditional fee for service. The ad keeps haunting me of the same Medicare, only better, but it even states in the ad people who choose fee for service can continue to have the same benefits, but they are going to be discriminated against because seniors in the traditional fee for service are not going to be getting these expanded services.

Mr. THOMPSON. Well, right now the law says, Congresswoman, that the additional money going to Medicare Plus Choice or Medicare Advantage, whichever you call it right now, the extra money has got to go either for decreasing the beneficiary's premiums or have reduction in the beneficiary cost sharing or enhance benefits.

And we have seen the enrollments so far, and they have been complying with that. They have to file their rates, as well sa their expanded benefits and their premiums, and they have been doing that. The premiums have been going down and benefits have been increasing. So it has been good.

Ms. CAPPS. Let me just raise a question. I want to give a minute to my colleague who will not get a chance to, Mr. Allen. So I am going to watch the clock.

I will say basically the same thing again. The private insurance market has been touted by the administration and the House Republicans as the answer to Medicare's future financial challenges.

We have seen in my district Medicare Plus Choice. The HMOs leave by the droves after raising their premiums.

So you are going against the history that my seniors know. This notion that plans are going to complete to serve an older, sicker, poorer population is hard for me unless they are vastly overpaid to do so.

Now my question. What is the basis for which you are stating, and I want to give you a minute to answer and let my colleague take the last minute? Are you suggesting that private markets are really more reliable even though they are in competition with each other and that their CEOs have to be paid handsomely? And then traditional Medicare, which has provided low cost, reliable coverage for seniors——

Mr. THOMPSON. We think that it is going to allow for choice, and we think the choice is going to make more efficiencies in the market, and we think the costs will go down.

And we have been seeing that the Medicare Plus Choice, Medicare Advantage are coming back into the market. There is a lot of indication they are coming back into the market, and we see that there is going to be——

Ms. CAPPS. They are coming back in the market because they are being paid handsomely to do that.

Mr. THOMPSON. Well, they are coming back into the market, and they are coming back with better benefits, too.

Ms. CAPPS. And there is no reason that they have to stay. There is no fixed coverage that they have to stay.

Mr. THOMPSON. No, that is true.

Ms. CAPPS. And so they can go up with inflation, as everything else in health care has been going up. Again, the seniors in my district that I have talked to, choice is not what they are asking for. Reliability, the Medicare they have always known and trusted. That is why you are having to run the ads, because there is a huge amount of lack of trust of this program in the community.

Mr. THOMPSON. Well, I think we have to run the ads because the Congress and the law tells us we have to.

Ms. CAPPS. No.

Mr. THOMPSON. We have to inform it, and we have to do it, and I am confident that your people want choice as much as the people that I——

Ms. CAPPS. Not what they tell me.

I will turn now to my colleague, Mr. Allen.

Mr. THOMPSON. Thank you.

Mr. NORWOOD. Mr. Allen, watch the clock.

Mr. ALLEN. I thank the gentlelady for yielding.

In Maine my seniors are very unhappy with this law for the reasons that Ms. Capps expressed. I just wanted to ask you quickly. I have co-sponsored a bipartisan bill to fund studies of the comparative effectiveness and cost effectiveness of prescription drugs, a bipartisan bill. The Medicare law contains a similar authority for AHRQ, but the President's budget contains no funding.

There are in the law a set of requirements, a set of time lines, and I am wondering today if you can commit to meeting those time lines that are set forth for this particular initiative.

Mr. THOMPSON. In fiscal year 2004, AHRQ invested $12 million for the related activities on the conduct of research, and I can assure you that we are going to meet the time lines.

Mr. ALLEN. I thank you.

Mr. NORWOOD. I thank you, Mr. Allen.

Mr. Secretary, there are a number of people who wish to put some questions in writing, and we would appreciate it if you would answer them. Mr. Pickering, I believe.

Mr. PICKERING. Yes, Mr. Chairman.

Mr. Secretary, I have some questions on the self-injectable issue——

Mr. THOMPSON. Right.

Mr. PICKERING. [continuing] that I would like to be addressed. I will submit those for the record. I know your time is short, and my colleague from California——

Mr. NORWOOD. We are all very grateful for you spending 3 hours with us.

The Secretary has agreed to take one more set of questions, and that will be the end of the hearing, and with that, I recognize Ms. Bono for 8 minutes.

Ms. BONO. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here.

My questioning is of a completely separate matter than that of my colleagues.

Mr. THOMPSON. Congressman Pickering, just get them. We will get you a response to your questions.

Sorry.

Ms. BONO. I would like to speak about the Ryan White Care Act. In my district, I have a community clinic that is really exemplary, the Deserts AIDS Project. The fiscal year 2005 budget flat funds and actually decreases Titles I and III in the Ryan White Care Act. The combination of that, along with the crisis California is facing with our budget, I am concerned my clinic is going to suffer, and I was wondering if you could tell me what you think this might mean to the grantees of the Ryan White Care Act.

Mr. THOMPSON. We decided, Congresswoman, that the money, since we were limited in the amount of resources we had in putting together the budget, that it would be better to put the Ryan White money into ADAP, into drugs, and that is where the increased money went.

Ms. BONO. However, California is cutting its ADAP funding so this will continue to be a major issue, and I am concerned because we have made tremendous progress with AIDS and HIV. We were able to keep people who are HIV positive from developing full blown AIDS, and I am concerned that we are going to suffer a setback if this is the trend that we are going to be following here.

Mr. THOMPSON. I would love to sit down and talk to you about how we might be able to help California in this, but most of the people that have some in to see me—I am very active in the AIDS fight. As you probably know, I am chairman of the Global Fund, and I have put a lot of effort into meeting with AIDS groups all over the country, and they advise me that they would much rather see the money we have put into ADAP for the use of medicine to

get to individuals that are HIV positive, and so that is where we put the money.

Ms. BONO. Well, I would really like to sit down and work with you further on this, and I will take this opportunity to invite you to my district to visit this clinic.

As well, you and I have spoken before along with Senator Frist about the IMPACT bill in trying to address the issue of childhood obesity, and I am glad to see that this issue has been elevated.

You also have the STEPS to a Healthier U.S. initiative, and I believe you doubled the funding.

Mr. THOMPSON. Yes.

Ms. BONO. Can you explain to me? I have some concerns with my own legislation. Even though my name is on it, I do not know how you legislate health or how you legislate fitness. I would love to hear about the success that you have already made and what we can look forward to in the near future with this new initiative you have.

Mr. THOMPSON. I happen to be extremely passionate about this subject. We rolled out yesterday at a press conference with the Ad Council five new ads that are very funny, and they really point out.

We are also teaming up with Sesame Street in order to get to children. We are putting out the VERB Program through CDC. We have spent $289 million over the last 5 years in developing this program. This is called VERB.

We are getting information out all over the country. The Surgeon General, I have requested him to go to schools in every one of the 50 States, and which he intends to do. I speak on the subject all over, and we have got this Healthier Steps for U.S., and what we are trying to do there is we are trying to get cities to compete against each other across America to improve their quality of health in several areas: reduction in diabetes, reduction in asthma, and reduction in obesity, especially with children; and putting some dollars in to developing good walking paths and being able to set up programs.

So far we had 150 applications for $13 million, which would indicate that there is a real desire out there. We have $44 million this year. We are going to put that into some other programs to help cities. We are hoping to be able to get a lot of competition. We think that is the best way to do it, just the way we fought cigarette about 25 to 30 years ago. We want to now bring the whole force of the Nation in trying to develop programs to get people to start looking at themselves and say, you know, chunky is good, but slim is better.

Ms. BONO. Well, I appreciate your leadership on this.

Mr. THOMPSON. Thank you.

Ms. BONO. Senator Frist and I have worked on it for quite some time. I definitely appreciate all you have done.

But one last topic that I do not hear much coming from you on is the Women's Health Initiative. I would like this issue to be elevated.

Mr. THOMPSON. I was just given the Women's Health Advocate of the Year Award. So I don't know.

Ms. BONO. I am sorry. I did not know that. I will follow your awards more closely from now on, Mr. Secretary.

Seriously though, the Women's Health Initiative on hormone replacement therapy is something that women are as concerned as confused about. I hope you will continue to focus efforts on this as well.

And I am going to yield my time, if I can, to Mr. Towns if the Secretary could just briefly comment on Women's Health Initiative.

Mr. THOMPSON. Our budget includes $8 billion for discretionary activities which are targeted directly toward women's health. This is an increase of $380 million, or 5 percent, and when you take a look at the overall discretionary budget of 1.2 percent for the total budget, you can see we really put the emphasis on women's health, and we are doing a lot of things.

I wish I had time to go through all of the things we are doing, but it is quite remarkable. It is never enough, but we are going in the right direction.

Ms. BONO. You are definitely doing that. Just pinpointing one specific area on hormone replacement therapy for women, I think it is a topic that is very confusing right now to the public.

Mr. THOMPSON. NIH, you know, is doing a study on that right now as we speak.

Ms. BONO. Yes, and that is what I am referring to. So I just want to thank you for that, and make sure that you keep emphasis on it as well.

And I am happy to yield to my colleague with that.

Thank you.

Mr. THOMPSON. I have got a wife and two daughters that are in the women's health movement, and they talk to me about this every single day.

Ms. BONO. They are good people.

Thank you, Mr. Secretary.

Mr. TOWNS. Thank you very much for yielding.

Mr. Secretary, first of all, let me join my colleagues in saying that I really appreciate your involvement in terms of obesity.

Mr. THOMPSON. Thank you.

Mr. TOWNS. You know, I read the article in the Washington Post, and I watched CNN last night, and I think that is a giant step in the right direction.

You know, what I would like to ask of you, I have a bill 2024 which would address the issue, and actually this ban will assist those which really do not fall into the regular category and that they will need additional help.

In that vein, I would ask you to seriously consider supporting efforts that I will be making later in the year to remove the current restrictions in Medicaid law which bans reimbursement for the use of any weight loss drug.

I do not want you to answer me today. I really want you to think about this and maybe have your staff to sit down with my——

Mr. THOMPSON. What is the number of your bill?

Mr. TOWNS. Twenty, twenty-four.

Mr. THOMPSON. Twenty, twenty-four. I will look at it.

Mr. TOWNS. Right, and I think that this would make it possible, you know, for many others to benefit from it, you know, those that might not be able to just benefit from exercising and all of the other kind of things, but the point is that I think that we need to

do as much as we can because, as you indicated, 40,000 preventable deaths, you know, attributed to the disease of obesity. So I think that when you look at that that anything that we can do, I think we need to try and do it.

So if you could just ask your staff to——

Mr. THOMPSON. And it is extremely serious in the minority communities, and I would appreciate any suggestions you might have on how we can do a better job to get information out to the African American community. I really would like that.

Mr. TOWNS. Well, thank you very much. I am anxious and eager to work with you on that——

Mr. THOMPSON. Thank you very much.

Mr. TOWNS. [continuing] as I have done on many issues in the past.

Mr. THOMPSON. Thank you.

Mr. NORWOOD. I will ask unanimous consent to keep the record open for 14 days, Mr. Secretary, so that members can submit questions and have additional materials for the record.

With that, again, a large thank you very much for being here. You have been absolutely great, and the hearing is adjourned.

Mr. THOMPSON. You are a wonderful Chairman.

Mr. NORWOOD. Thank you.

[Whereupon, at 5:09 p.m., the hearing was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons is pleased to comment on the Administration's FY2005 Health Care Priorities. We thank Chairman Barton and the other distinguished Members of the Committee on Energy and Commerce who worked diligently to pass the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). This legislation guaranteed a 1.5 percent increase in physician payments in 2004 and 2005, averting a 4.5 percent cut. Surgeons historically have had particularly high Medicare participation rates. That legislation took an important first step in guaranteeing the profession's continued participation in the program.

CMS has performed exemplary work in implementing the MMA. We applaud Secretary Thompson and the agency for completing the sizeable amount of work it had to accomplish in the limited time it had to do so. Due to the recognition of CMS' constraints in developing policies in many of these areas, we have we have limited our comments to those areas over which CMS has some degree of latitude. It is within that context that we offer the following comments.

THE SUSTAINABLE GROWTH RATE

The SGR includes not only physicians' services, but also services and supplies furnished incident to physicians' services, such as drugs. According the final rule for the Medicare Fee Schedule published in the November 11, 2003 *Federal Register,* drugs make up 12.3 percent of allowed charges included in calculating the SGR for 2002, which is a 41 percent increase over two years. It is worth noting that in 2002, the last year for which data is available, 20 drugs are in the 100 fastest growing services. This growth was greater than the other two categories of SGR spending—laboratory services and physician services. Furthermore, spending for major procedures has remained constant.

The growth in drug utilization has been largely a result of the introduction of new and generally very expensive drugs. New drugs are going to continue to be introduced and with life expectancy continuing to grow, people will use drugs for chronic conditions for a longer period of time. With all of these factors combined, we believe spending on drugs will continue to escalate for many years.

Finally, the use of drugs varies significantly by specialty. According to CMS, small specialties received more than 40 percent of their Medicare income from drugs. Sixteen specialties, including the large specialties of internal medicine, family practice, general practice, obstetrics-gynecology, and general surgery, had five percent or less of their Medicare income from drugs. Thus, the administration of drugs by a few

specialties of small size has the unintended consequence of reducing payments for all specialties.

CMS clearly has the authority to remove drugs from the SGR calculation. At one time, two different definitions of "physicians' services" appeared in statute—one that applied generally to the fee schedule and one that only applied to computing the SGR. The one that applied generally to the fee schedule permitted the Secretary some discretion to define in regulation what to include. In the final fee schedule regulation for 1992, drugs were excluded from the definition of "physicians' services". The other definition, the one that applied to computing the SGR, did include drugs. However, the Deficit Reduction Act of 1997 deleted the section containing that reference. Consequently, we would argue that CMS must remove drugs from the SGR calculation.

Our second concern with the SGR involves the MMA which contained a provision giving physicians a positive update of 1.5 percent in 2004 and 2005. Ironically, the law went on to say this modification is not to be reflected in the SGR calculation as a change in law. No rationale is offered in the report language. This sabotages the point of the SGR by keeping it from rising to reflect legitimate increases in spending originating in the law.

By not adjusting the SGR to account for this increase in spending, expenditures will far exceed the SGR and the result will be years of negative updates. On the other hand, if fundamental changes in the update can be agreed to, the cost of making the changes will be artificially inflated by not including the updates in 2004 and 2005 in SGR. It is entirely possible that this "cliff" will be so great that it will cause the defeat of a proposal which is otherwise acceptable. We urge CMS to support legislation that would include in the SGR the increases in spending resulting from use of the new MMA benefits, as well as any additional services that are triggered by these benefits.

SUPPLEMENTAL PRACTICE EXPENSE SURVEYS

CMS established a process in its May 3, 2000 rule on Criteria for Submitting Supplemental Practice Expense Survey Data under which it will accept and use data collected or developed by entities and organizations to supplement the data it normally collects in determining the practice expense component of the physician fee schedule. This rule was developed for data submitted for use in computing the practice expense RVUs for the 2001 and 2002 physician fee schedules and has been used by CMS to evaluate subsequent supplemental data submitted to them by medical specialty societies. The College believes there has been and likely will be in the future a legitimate need for specialties to submit supplemental data for various reasons, the most common being a sample size from the SMS survey that is too small. A prime example of this is in the case of thoracic surgery and vascular surgery where sample size from SMS data were considered to be too small to provide valid data.

The May 2000 rule states that CMS would use a weighted average (based on the number of survey responses) of the supplemental data submitted to them by specialty societies and existing data from the American Medical Association's Socioeconomic Monitoring Survey (SMS) for those specialties that are already represented in the SMS data. CMS has in the past blended specialties' supplemental survey data with prior survey data from the SMS. The College believes that CMS should develop and hold to a consistent policy in regards to whether or not to use a weighted average of supplemental data and the existing SMS data already being used. While we believe there could be isolated cases in which exceptions need to be made, a strong and compelling rationale should be provided to CMS by specialty societies. In addition, for any future supplemental survey data CMS is considering using without blending with existing SMS data, the agency should include its rationale for doing so in a proposed notice that would be subject to public comment.

PROFESSIONAL LIABILITY INSURANCE GEOGRAPHIC PRACTICE COST INDEXES

As a result of the most recent escalation in the costs of Professional Liability Insurance (PLI) premiums nationwide, CMS updated the Geographic Practice Cost Indexes (GPCIs) based upon actual 2001 and 2002 premium data and forecasted 2003 premiums using a mean rate of change. We thank CMS for its methodological change in using forecasted data for 2003. However, as we outlined in our comments on the proposed 2004 physician fee schedule rule, we believe that CMS should predict 2004 premiums based on the rate of growth in the PLI premiums from 2001 to 2003, but not blend the predicted 2004 data with data from as far back as 2001. Using 2004 projected data would more accurately capture the PLI premium in-

creases that have recently occurred, rather than diluting these increases with data from previous years

The College appreciates CMS sharing with the AMA/Specialty Society Relative Value Update Committee (RUC) for review at its February 2004 meeting the professional liability insurance premium data utilized in establishing the PLI GPCIs. We also appreciate CMS providing the list of CPT codes with their assigned category of risk (i.e., surgical or non-surgical). During this meeting, the RUC held a lengthy discussion concerning the disparity between the data provided and the actual PLI costs currently incurred by physicians. The RUC concluded that the process of averaging the data which is highly variable state by state and even among regions within a state do not provide an appropriate reflection of costs incurred by practitioners in high-risk states.

We are encouraged that CMS has indicated an interest in working closely with the RUC on additional data collections that would provide more reliable and recent data, both for the use of the GPCIs and the establishment of the Medicare Economic Index (MEI) weights for the malpractice component of the fee schedule. The College looks forward to participating in this effort.

ADJUSTING RELATIVE VALUE UNITS TO MATCH NEW MEI WEIGHTS

As CMS' impact analysis shows, adjusting the Relative Value Units (RVUs) to match the new MEI weights increased the malpractice RVUs by more than 20 percent which, in turn, increases the payment for those specialties that perform services with high malpractice RVUs including anesthesiology, cardiac surgery, emergency medicine, neurosurgery, orthopedic surgery, thoracic surgery and vascular surgery, all which increase by approximately one percent.

We understand that CMS believes that by matching the aggregate pools of RVUs to the rebased MEI weights, Medicare's payments for physician work, practice expense and malpractice will more closely match the proportion of expenses incurred by physicians in these categories. We support the reweighting of the PLI component to increase the proportion of Medicare payments that go towards professional liability premiums. However, as we stated in our comments to the final rule published in the November 7 2003 *Federal Register,* altering work and practice expense to maintain budget neutrality compromises the integrity of the work and practice expense relative values currently assigned to codes.

Due to the mandates of the MMA, which exempt some of the changes to work and practice expense RVUs from budget neutrality, the number of work and practice expense RVUs have been increased. As a result, the adjustments to the work and practice expense RVUs are less than those published in the November final rule. The revised adjustments are 0.15 percent (0.9985) for physician work, -1.320 percent (0.9868) for practice expense, and 20.61 percent (1.2061) for malpractice. Although we continue to disagree with any adjustments to work and practice expense as a means of achieving budget neutrality, we are pleased that the alterations made to these values are considerably less than originally announced.

FIVE-YEAR REVIEW OF PLI

While we appreciate the adjustments CMS has made to the PLI component of the 2004 fee schedule, these modifications are minor and because they are budget neutral, the impact on most surgeons will be minimal. As the cost of insurance continues to mount, the number of physicians experiencing a crisis in obtaining and affording professional liability insurance in this country is growing rapidly. With 19 states in crisis and insurers in state after state raising their rates or ceasing to offer certain kinds of insurance, the need for CMS and Congress to act has never been greater.

We were encouraged to hear CMS officials announce at the February 25, 2004 Practicing Physicians Advisory Commission meeting that CMS will include in the Spring proposed notice for the 2005 Medicare Physician Fee Schedule a discussion of the Five-Year Review of malpractice RVUs. The College believes it is critical that CMS and the specialty societies invest a great deal of effort into the 5-Year Review of malpractice RVUs. We urge CMS to consider whether the current method of allocating RVUs is appropriate or whether some alternative would better meet physicians' needs.

Additionally, the College has previously asked CMS to "model" an approach that would calculate PLI RVUs using the PLI premium of the specialty that performs the procedure most frequently. We believe this proposed methodology would more accurately reflect the expense and risk of various services in calculating the malpractice RVUs by accounting for the specialty most commonly performing each procedure. In its comment letter to the 2004 proposed rule, the RUC also recommended

that CMS consider the use of the dominant specialty rather than a weighted average of all specialties that perform the service. We urge CMS in the strongest terms possible to review these proposals and include them as an option for public comment in the 2005 proposed fee schedule, along with other alternatives that are being considered for development of malpractice RVUs.

While an improved methodology is needed to redistribute PLI reimbursement to those specialties that are most impacted by the rising costs, unless Medicare payments are increased to offset the increased expenses of PLI, patients' access to care will continue to be endangered and the problem will only intensify over time. We reiterate our support of the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, H.R.5. In addition, Congress needs to provide new money for addressing this crisis before more physicians are forced to leave their patients and move to states where liability is more affordable, limit their services, or abandon their practices altogether.

CONCLUSION

One of the greatest achievements of the Medicare program is the access to high-quality care it has brought to our nation's senior and disabled patients. This level of access cannot be expected to continue uninterrupted in the face of continued cuts and growing liability premiums. We cannot emphasize enough how important it is for Congress and the Administration to take steps ensuring that physician payments adequately reflect the cost of doing business.

Thank you for your consideration of Medicare payment policies as you review the Administration's FY2005 Health Care Priorities. The College appreciates this opportunity to present its views and looks forward to working with you to ensure continued access to Medicare.

[At the time of printing the Department of Health and Human Services had failed to respond to additional questions.]